Assessing the Community Needs of Mental Health Residential Care Service Users in the Republic of Moldova

(STUDY REPORT)

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Republic of Moldova

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SUMMARY

Background: Mental health problems are a major clinical and social issue in the Republic of Moldova, accounting for a significant share of disability and ranking in top five of the ten lines in the hierarchy of conditions. The incidence rate has been growing in the Republic of Moldova to reach approximately 15 thousand a year (14,655 in 2011), i.e. 411.4 per 100 thousand population, and a prevalence rate of 97,525 thousand people in 2011, i.e. 2,737.9 per 100 thousand population. Psychiatric care system provides for scanty mental health services at community level, aiming mainly at centralized hospital-based therapy through a network of three psychiatric hospitals tallying up 1,860 beds and 4 psycho-neurological boarding houses with 1,890 beds, thus fuelling up patient stigmatization.

Objectives: The *purpose* of this study was to assess the individual needs of beneficiaries and their level of autonomy within residential care for the planning of mental health system reforms and deinstitutionalization in the Republic of Moldova. This study was commissioned by the Ministry of Labour, Social Protection and Family and by the Ministry of Health, with the World Health Organization support, to provide for effective enforcement of article 19 of the UN CRPD. The study pursued the following *goals*: To evaluate the level of autonomy of the psychiatric hospital and psycho-neurological boarding house residents by using a representative sample of 10 per cent of the total number of patients / residents and cross-comparison; To evaluate four psycho-neurological boarding houses for adults and three psychiatric hospitals; To develop recommendations for planning the deinstitutionalization of people with mental health problems and community placement based on the study findings.

Methodology and results: The study made use of two global tools: questionnaire for individual assessment of mental health facility residents, and institutional assessment questionnaire. All interviewees were divided into four categories by one's degree of dependence and readiness to live independently in the community. Only 1.2% of respondents from PNHB were fully dependent on a third party or specialized services, making up category 4, requiring continuous care and support. In PH this category of people is absent.

Conclusions: The condition of respondents was worse in PNBH than in PH. However, yet, those ready to be deinstitutionalized accounted for most of respondents there. All hospitals had the resident's consent to admission and treatment, whereas there was no consent in PNBH whatsoever. It is quite obvious that both the hospitals and residential care system do not achieve their intended purpose, meaning that the majority of residents may be deinstitutionalized without any support therapy.

Key words: Republic of Moldova, level of autonomy, community needs, degree of dependence.

RESUMO

Background: Problemas de saúde mental são um grande problema clínico e social na República da Moldávia, representando uma quota significante de deficiência, sendo classificada no top cinco das dez linhas na hierarquia das condições. A taxa de incidência tem sido crescente na República da Moldávia, atingindo cerca de 15.000 por ano (14,655 em 2011), ou seja, 411,4 por 100 mil habitantes, e uma taxa de prevalência de 97.525 pessoas em 2011, ou seja, 2,737.9 por 100 mil habitantes. Sistema de atendimento psiquiátrico fornece serviços de saúde mental escassos a nível da comunidade, visando principalmente terapia hospitalar, centralizada, através de uma rede de três hospitais psiquiátricos, com 1.860 camas e 4 sanatórios psico- neurológicos com 1890 camas, assim alimentando-se a estigmatização do paciente.

Objetivos: O objetivo deste estudo foi a avaliação das necessidades individuais dos beneficiários e do seu nível de autonomia dentro de cuidados residenciais, para o planeamento de reformas de saúde mental e desinstitucionalização na República da Moldávia. Este estudo foi encomendado pelo Ministério do Trabalho, Proteção Social e da Família e pelo Ministério da Saúde, com o apoio da Organização Mundial da Saúde, para determinar o cumprimento eficaz do artigo 19 da Convenção da ONU. O estudo tem os seguintes objetivos: Avaliar o nível de autonomia dos residentes nos hospitais psiquiátricos e sanatórios psico-neurológico, usando uma amostra representativa de 10 por cento do número total de pacientes/residentes e comparação cruzada; Para avaliar quatro sanatórios psico-neurológicos para adultos e três hospitais psiquiátricos; Para desenvolver recomendações para o planeamento da desinstitucionalização das pessoas com problemas de saúde mental e colocação na comunidade com base nos resultados do estudo.

Metodologia e resultados: O estudo fez uso de duas ferramentas globais: questionário para a avaliação individual dos residentes do estabelecimento de saúde mental, e questionário de avaliação institucional. Todos os entrevistados foram divididos em quatro categorias conforme com o grau de dependência e preparação de viver de forma independente na comunidade. Apenas 1,2% dos entrevistados de PNHB eram totalmente dependentes de terceiros ou serviços especializados, tornando-se a categoria 4, que necessitam de cuidados e apoio contínuo. No PH esta categoria de pessoas é ausente.

Conclusões: A condição dos entrevistados foi pior em PNBH que em PH. No entanto, ainda, aqueles que estão prontos para ser desinstitucionalizados correspondem com a maior parte dos entrevistados. Todos os hospitais tinham o consentimento do utente para admissão e tratamento, enquanto não houve consentimento qualquer em PNBH. É bastante óbvio que tanto os hospitais como também a sistema de assistência residencial não atingem a sua finalidade, o que significa que a maioria dos utentes pode ser desinstitucionalizados, sem qualquer terapia de suporte.

Palavras-chave: República da Moldávia, nível de autonomia, as necessidades da comunidade, grau de dependência.

RESUMEN

Background: En Moldavia problemas de salud mental son un importante problema sanitario y social y es una causa importante de discapacidad, que ocupa las cinco primeras posiciones en la jerarquía de diez enfermedades. El aumento de la tasa de incidencia de alrededor de 15.000 por año (14.655 en 2011), es decir 411,4 a 100.000 habitantes y la prevalencia de 97.525.000 personas en 2011, es decir, de 2.737,9 a 100.000 habitantes. Sistema de atención psiquiátrica proporciona un número insuficiente de servicios de salud mental en la comunidad, se orienta principalmente en el tratamiento centralizado hospitalizados a través de tres hospitales psiquiátricos con una capacidad total de 1.860 camas y 4 abordaje psico-neurológico para 1.890 camas, lo que contribuye estigmatizar a los pacientes.

Objetivos: El objetivo de este estudio fue evaluar las necesidades individuales de los beneficiarios y su grado de autonomía con respecto al entorno institucional para la planificación de proceso de reforma e institucionalización de los servicios de SM en Moldavia. Este estudio se inició Ministerios intención de Trabajo, Familia y Protección Social y Salud, con el apoyo de la Organización Mundial de la Salud para el ejercicio efectivo de arte. 19 Convención de la ONU sobre los Derechos de las Personas con Discapacidad. Los objetivos del estudio son: Evaluación de la autonomía de los beneficiarios de los hospitales psiquiátricos y abordaje psico-neurológico en una muestra representativa del 10% del total de pacientes / residentes y la evaluación comparativa; 4 evaluación psico-neurológico hospitalizado adulto y tres hospitales psiquiátricos; Recomendaciones para la desinstitucionalización del plan de las personas con SM y su colocación en instituciones de la comunidad, basados en los resultados del estudio.

Metodología y resultados: El estudio fue promovido por la aplicación de dos instrumentos globales: los destinatarios del cuestionario de evaluación de la persona y el cuestionario de evaluación institucional. Todos los encuestados se dividieron en cuatro categorías en función del grado de autonomía y que se preparan para una vida independiente en la comunidad. Sólo el 1,2% de las personas de abordaje psico-neurológico están incluidos en la categoría IV - totalmente dependiente de un tercero o de servicios. En los hospitales psiquiátricos como la categoría de las personas desaparecidas.

Conclusiones: Términos encuestados son peores en el abordaje psico-neurológico que en los hospitales psiquiátricos. Sin embargo, todavía institucionalización está listo para la mayor parte de los encuestados. Todos los hospitales tenían el consentimiento para el ingreso y tratamiento, mientras que no hubo consentimiento en un internado. Es bastante obvio que los dos hospitales y sistema de atención residencial no lograr el objetivo, lo que significa que la mayoría de los residentes se pueden desinstitucionalizados sin ningún apoyo especializado.

Palabras clave: Moldavia, nivel de autonomía, las necesidades de la comunidad, la dependencia.

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AUTHOR'S DECLARATION

I declare that this work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree. Any views expressed in the dissertation are those of the author. The dissertation has not been presented to any other university for examination.

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ACRONYMS

MH	Mental Health
MoH	Ministry of Health
MoLSPF	Ministry of Labor, Social Protection and Family
PHF CPH	Public Healthcare Facility – Clinical Psychiatric Hospital
PHF PH	Public Healthcare Facility – Psychiatric Hospital
PNBH	Psycho-Neurological Boarding House
UN CRPD	UN Convention on the Rights of Persons with Disabilities
WHO	World Health Organization
LPA	Local Public Authorities
CMHC	Community Mental Health Center
FMC	Family Medicine Center
NHIC	National Health Insurance Company
RHDC	Regional Health Development Center on Mental Health in South-eastern Europe
RP	Psychiatric Room
SEEHN	South-eastern Europe Health Network
PHCF CPH	Public Health Care Facility Clinical Psychiatric Hospital
PHCF	Public Health Care Facility

Basic package (basic package of mandatory health insurance)

CHAPTER I - INTRODUCTION

1.1 Information about The Republic Of Moldova

Coat of arms

Moldova, officially the **Republic of Moldova,** is a landlocked country in Eastern Europe located between Romania to its West and Ukraine to its North, East and South. Its capital city is Chişinău. **The population** is 3,559,500. **GDP** (PPP) per capita is $4,182 and **GDP** (nominal) per capita is $2,038. Moldova declared itself an independent state with the same boundaries as the Moldavian Soviet Socialist Republic in 1991, as part of the dissolution of the Soviet Union. A new constitution was adopted on July 29, 1994. A strip of Moldova's internationally recognized territory on the east bank of the river Dniester has been under the *de facto* control of the breakaway government of Transnistria since 1990.

As a result of a decrease in industrial and agricultural output since the dissolution of the Soviet Union, the relative size of the service sector in Moldova's economy has grown to dominate its GDP and currently stands at over 60%. Moldova remains, however, the poorest

country in Europe[1].

Moldova is a parliamentary republic with a president as head of state and a prime minister as head of government. It is, among other organizations, a member state of the United Nations, the Council of Europe, the World Trade Organization (WTO), the Organization for Security and Cooperation in Europe (OSCE), the GUAM Organization for Democracy and Economic Development, the Commonwealth of Independent States (CIS) and the Organization of the Black Sea Economic Cooperation (BSEC). The country aspires to join the European Union[9] and, to this end, has implemented an initial three-year action plan within the framework of the European Neighbourhood Policy (ENP).

Moldova is a unitary parliamentary representative democratic republic. The 1994 Constitution of Moldova sets the framework for the government of the Country. A parliamentary majority of at least two thirds is required to amend the Constitution of Moldova, which cannot be revised in time of war or national emergency. Amendments to the Constitution affecting the state's sovereignty, independence, or unity can only be made after a majority of voters support the proposal in a referendum. Furthermore, no revision can be made to limit the fundamental rights of people enumerated in the Constitution.

The country's central legislative body is the unicameral Moldovan Parliament (*Parlament*), which has 101 seats, and whose members are elected by popular vote on party lists

[1] *CIA World Factbook.*

every four years.

The head of state is the President of Moldova, who is elected by the Moldovan Parliament, requiring the support of three fifths of the deputies (at least 61 votes). The president of Moldova has been elected by the Parliament since 2001, a change designed to decrease executive authority in favour of the legislature. The president appoints a prime minister who functions as the head of government, and who in turn assembles a cabinet, both subject to parliamentary approval.

The 1994 constitution also established an independent Constitutional Court, composed of six judges (two appointed by the President, two by Parliament, and two by the Supreme Council of Magistrature). The Court is invested with the power of judicial review over all acts of the parliament, over presidential decrees, and over international treaties, signed by the Country.

1.2 Legislation in Mental Health in Republic of Moldova

Millions suffer from mental health problems, which, if left untreated, build up into a huge tide of distress, disability and economic loss, burdening the social, education, legal and health care systems alike as well as individuals and families. Despite treatment options being available and positive trends in psychiatric care in recent years, people with mental health problems or disabilities still face problems, such as social exclusion, stigmatization, discrimination and violation of personal dignity and fundamental human rights. The methods employed to treat people with mental health problems has significantly evolved over the last decades of the 20th century as the overall philosophy of psychiatric care moved away from the residential care system. In this context, the Republic of Moldova signed the Mental Health Declaration for Europe adopted in Helsinki, Finland (2005), whereby the country selected mental health care as a priority, as well as the UN Convention on the Rights of Persons with Disabilities in 2007, which was later ratified by Law no.166 of 9 July 2010.

The importance of mental health is highlighted in the key policy papers put up by the Ministry of Health (MoH) and endorsed by Government:

- the Law on Mental Health no.1402-XII of 16.12.1997 with subsequent changes;
- the Health System Development Strategy of the Republic of Moldova 2008-2017, approved by Government Decision no.1471 of 24.12.2007;

- the National Health Policy in the Republic of Moldova (Chapter XII. "Enabling conditions for better mental health"), approved by the Government in May 2007 as per GD no.886 of 06.08.2007;

- the National Program for Mental Health 2012-2016, approved by GD no.1025 of 28.12.2012.

- the Ministerial order nr.610 from May 24, 2013 "About Strategy of development of mental health services on community level and integration of mental health in primary health care for 2013 – 2016"

The above papers targeted the deinstitutionalization of people with mental health problems, which one may also access under the MoLSPF policy papers, as follows:

- Law no.169-XVIII of 9 July 2010, endorsing the Strategy for Social Inclusion of Persons with Disabilities (2010-2013);

- Law no.60-XIX of 30 March 2012, on the social inclusion of people with disabilities.

1.3 Organization of Mental Health system in Republic of Moldova

Psychiatric and behavioural disorders are major social and clinical problems in the Republic of Moldova, accounting for a significant share of total disability, ranking among the top five in the hierarchy of ten most disabling conditions. About 50 per cent of the psychiatric patients followed up are disabled and make up the most vulnerable tier of the population[2]. Mental disorders occur in many Republic of Moldova residents, as indicated by the rising incidence tallying up to some 15 thousand people a year and an overall prevalence of approximately 100 thousand people each year[3]. About 60 thousand psychiatric patients are actively followed up by the health system, of which around 28 thousand people have an ascertained disability. Pursuant to the National Center for Health Management data of 2012, the overall incidence of mental and behavioural disorders achieve to 360.5 cases per 100 thousand inhabitants versus 382.3 cases in 2011, of which 300.9 per 100 thousand were adults and 588.8 per 100 thousand were children[4].

[2] the Ministerial order nr.610 from May 24, 2013 "About Strategy of development of mental health services on community level and integration of mental health in primary health care for 2013 – 2016"

[3] National Program for Mental Health 2012-2016, approved by GD no.1025 of 28.12.2012.

[4] STATISTICAL YEARBOOK OF THE REPUBLIC OF MOLDOVA 2012, http://www.statistica.md/public/files/publicatii_electronice/Anuar_Statistic/2012/anuar_2012_eng.pdf

Driven by the social and economic issues during the transition period, the situation in the mental health system of Moldova has continuously worsened to currently reach to the point when it is no longer capable of meeting people's needs. The treatment approaches currently employed by the mental health system are based on the out-dated model of care and are not aligned to the mental health needs of the population. The main focus is centralized hospital-based care, which has a number of significant shortcomings, the most severe of which include discontinuity of services and removing patients from their homes. This precludes the Country from setting up an adequate system centred on patient needs. Psychiatric care does not include community mental health services, once it remains focused on centralized inpatient care, delivered within three psychiatric hospitals (total: 1,860 beds) and 4 psycho-neurological boarding houses (total: 1,890 beds). This fuels patient stigmatization, in particular by prescribing mandatory registration of patients and limiting their rights to perform certain jobs.

Residential care is one of the most in demand and expensive types of care due to underdeveloped alternative social services. These groups of people face quite specific problems, requiring a customized approach focused on recovery measures and social (re)integration. Residential care facilities subordinated to the Ministry of Labour, Social Protection and Family (MoLSPF) belong to the social care system and are highly-specialized service providing facilities, rendering care to the elderly and to the highly dependent disabled people, who have lost or have limited possibility of getting an active social life, and requiring intensive care or lengthy rehabilitation within specific specialized care facilities.

Currently, MH care is provided through the following services:

Pre-hospital emergency psychiatric care services

It consists of a mobile medical team within the Municipal Emergency Station Chisinau, Zonal Emergency Health Care (EHC) Substation "North", Zonal EHC Substation "South", Zonal EHC Substation "ATU Gagauzia", Zonal EHC Substation "Center", most often as calls and home visits to render first aid in psychotic conditions and transport to psychiatric hospitals nearby. At district level, emergency psychiatric care is provided by psychiatrists in the specialized outpatient care called upon by a family physician or by EHC staff, third parties (relatives, neighbours, police officers etc.) for consultation of relevant cases.

- ***Outpatient Services***
  - District-level psychiatric rooms;

Outpatient psychiatric care services are provided at the level of:

- District, by the psychiatrists from the specialized outpatient care division of district hospitals, consisting of a psychiatric office for adults and psychiatric room for children;
- Municipality of Chisinau, by the psychiatrists from the consultative department of the relevant TMA and the National Psycho-neurological Dispensary of the PHCF CPH;
- Municipality of Balti, by the psychiatrists from the specialized outpatient department of the FMC;
- Psycho-neurological Dispensary within the PHCF CPH.

The extra-hospital care in Moldova consists of the consultative outpatient department of the Clinical Psychiatric Hospital and daily rehabilitation department within the Psychiatric Hospital Balti..

Outpatient department (dispensary) (serving the population of Chisinau):

- subdivision for adults
- subdivision for children
- day care for children and adults

National Consultation Department (servicing the population from all over the country):

- subdivision for adults
- subdivision for children

The day care rehab ward (mixed) from within the PHCF PH Balti may service about 35 people with mental disorders.

- Community MH Centers: there are 4 CMHC and one National Center for Mental Health:

- *CCSM Ungheni*, created in 2007, covering 117,000 population;
- *CCSM Rezina*, created in 2010, covering 53,000 people;
- *CCSM Buiucani*, created in 2005, covering 138,000 people;
- *CCSM* Balti , created in 2010, servicing 146,000 people;
- *NCMH* created in 2011 and coordinating MH policy, programs and community services.

Inpatient Services

There are 3 hospitals representing hospital services in Moldova:

1. Clinical Psychiatric Hospital in Chisinau (CPH);
2. Psychiatric Hospital in Balti;
3. Psychiatric and Phthisiopulmonology Hospital in Orhei.

Psychiatric hospitals in Moldova have a well-defined area of coverage. CPH is covering the municipality of Chisinau, ATU Gagauzia and 17 districts in the center and south of the

country. Being a clinical facility, CPH also treats patients from other areas not covered by the hospital (about 800 each year). PH in Balti is servicing the municipality of Balti and 11 districts in the country's north. PH in Orhei covers 4 districts in the center of the country. There is a psychiatric ward in a general hospital only in the district-level hospital of Ocnita. The ward has 30 beds and is located in the city of Frunze, servicing the patients of the district of Ocnita.

Hospital services are provided within the PHCF SP and district hospital, including:

a. Emergency aid;
b. Medical, social and psychological rehab;
c. Legal inpatient psychiatric expertise;
d. Coercive treatment (conventional regime, strict oversight).

Inpatient Psychiatric Care

It has a clinical mission (hospital) and treats all types and kinds of mental health issues, as well as all existing psychiatric disorders requiring 24/7 oversight, including, emergency care (providing health care services in major emergencies) and specialized psychiatric services with referral to outpatient specialists.

The psychiatric hospital sector of Moldova consists of 3 hospitals: CPH in Chisinau, PH in Balti, and PPP Hospital in Orhei.

There are 0.5 psychiatric beds per 1,000 population – basically at the level reported in many European countries[5]. The basic performance indicators in this hospital sector over the last 3 years show basically no trends in the number of discharged patients (21,407 in 2009 vs. 21,561 in 2010 vs. 21,503 in 2012).

No change in the average length of hospitalization – 33 in each of the years above;

The bed throughput was 231 vs. 353 vs. 349

Table 1Basic indicators for all psychiatric hospitals

Name of indicators	2012, CPH Costiujeni	2012, PH Balti	2012, PPP Orhei
Number of beds, avg. /year	1,110	770	200
Patients admitted	10,497	9,229	2,102
Patients discharged	10,385	9,027	2,091
Deaths	27	68	
Total patients at the year-end	936	839	
Bed turnover	9.4	11.8	10.5
Number of days / bed	328,774	306,185	70,211
Average length of stay	31.6	33.4	33.4

[5] Mental Health Atlas 2011, WHO

Bed throughput	296	397.6	351.0

- ***Residential Services***

The Ministry of Labor, Social Protection and Family is coordinating and ensuring the operation of 6 residential social facilities for adults and children: 2 facilities for children with severe mental disabilities located in the towns of Orhei and Hincesti, and 4 facilities for adults with mental disabilities (psychosocial disabilities and intellectual deficiencies) located in the municipality of Balti, districts of Dubasari, Soroca and Edinet, offering their beneficiaries social protection by providing social and health services, housing (indefinitely), care, nutrition, clothing and footwear, occupational therapy, cultural activities, kinesiotherapy, healthcare etc.

Table 2 Trends in the number of beneficiaries from the residential social facilities subordinate to the MLSPF, adults, 2009–2012[6]

Groups of beneficiaries	2009	2010	2011	2012
Elderly and people with physical disabilities	430	416	392	364
% drop in the number of beneficiaries as compared to the previous year	-23.0	-3.3	-5.8	-7.1
Adults with mental disabilities	1701	1690	1700	1688
% increase in the number of beneficiaries as compared to the previous year	-8.5	-0.65	-0.6	-0.7
Total, persons	2131	2106	2092	2052
% increase in the number of beneficiaries as compared to the previous year	-11.8	-1.17	-0.66	-1.9

The overall capacity of those subordinate facilities was 2,125 beds, including **1,665 in psychoneurological boarding houses** (Table 3).

Table 3 Number of beneficiaries and human recourses of social services subordinated the MoLSPF, 2012

	Year: 2012			
	Number of beneficiaries		Staff	
	Planned	Endorsed	Planned	Endorsed
Psychoneurological boarding house in the village of Brinzeni, district of Edinet	300	300	153.3	153.3
Psychoneurological boarding house in the village of Badiceni, district of Soroca	460	460	222.0	222.0
Psychoneurological boarding house in the municipality of Balti	550	550	254.0	244.25
Psychoneurological boarding house in the village of Cocieri, district of Dubasari	355	355	169.0	165.5
Total:	1,665	1,665	798.3	785.05

[6] Social Report,2012, MLSPF, 2012

1.4 Description of human resources in mental health services.

Human Resources available in 2012

Nr.	Professionals	Positions	Indicator
1	Psychiatrists (net of drug addiction specialists)	232	0.7 per 10,000 inhabitants;
2	Nurses: positions in the psychiatric hospital;	660	-
3	Psychologists: the staffing norms for psychiatric hospitals set forth 1 position per 80 beds, but it is not enforced;	23	-
4	Social workers: only in community services and 3 in psychiatric hospitals.	12	-

Prescribed psychiatric positions in 2012 – there is the situation planned in RM

	Total positions	For adults	For children
Total countrywide	232	195	37
In municipalities	25	24.5	0.5
Total in districts	58.75	42.5	16.25
Total in nationwide facilities (psychiatric hospitals)	148.25	128	20.25
total number in inpatient wards	142.5 planned	132.25	10.25

Psychiatrist positions filled in 2012

	Total positions	For adults	For children
Total countrywide	199.75 (86%)	166.75 (85.5%)	33 (89%)
In municipalities	21.75 (87%)	21.75 (87%)	-
Total in districts	55.25 (94%)	40.25 (94.7%)	15 (92.3%)
Total in nationwide	122.75 (86%)	104.75 (81.8%)	18 (88.9%)

facilities (psychiatric hospitals)			
total number in inpatient wards	117 (82%)	(82.4%)	8 (78%)

Deficit of psychiatrists in 2012

See the table below

	Total	For adults	For children
Country wide	32.25 (14%):	28.25 (14.5%)	4 (11%)
Total in municipalities	**3.25 (1.4%)**		
Total in districts	**3.5 (1.5%)**	**2.25**	**1.25**
Nationwide facilities	**25.5 (11%)**	**23.25**	**2.25**

1.5 Primary Health Care in Republic of Moldova.

The Network of healthcare facilities providing PHC consists of 5 Territorial Medical Associations (TMA) in the municipality of Chisinau with 12 family medicine centers (FMC) operating inside.

According to the National Center for Health Management data, there were 37 Family Medicine Centers (FMC) and 60 autonomous Health Centers (HC) operating in the Republic of Moldova at the beginning of 2012. In order to ensure the autonomy of PHC facilities, a gradual HC legal delimitation was started – a process that is ought to be completed by 2014 (MoH ordinance on the endorsement of the HC Legal Delimitation Program).

PHC facilities provide primary care to the patients enrolled of their own choice, based upon a written application, irrespective of someone's insurance status (insured or uninsured), including from other facilities in case of medical and surgical emergencies, or under any other situations justified from a medical standpoint. Irrespective of their legal form of setup, PHC facilities are part of the Roster of public health facilities duly endorsed by the Ministry of Health.

The overarching goal of PHC facilities is to improve the health of people through continuous development and strengthening of family medicine, with priority focus on measures aiming at preventing diseases within a defined population.

PHC facilities are classified based on the following criteria:

a) Catchment area

b) Population size

c) Legal form of setup

d) Complexity of PHC service provided

Based on the aforesaid criteria, PHC is provided at:

a) Family Medicine Centers (FMC)

b) Health Centers (HC), including the autonomous ones

c) Family Doctor Offices (FDO)

d) Health Posts (HP)

Family Medicine Centers

FMC are set up in urban areas and at the place of residence of local public authorities and are directly contracted by the NHIC. A FMC consists of rural PHC facilities – HC, FDO and HP – as per the provisions of the Roster of public health care facilities, holding premises and other fixed assets, medical equipment and gear, transportation means etc.

At the FMC place of residence, there is one or several family medicine stations, depending on the population size they serve and the number of primary care physicians.

FMC are classified as follows:

1) FMC of category III – up to 40,000 people;

2) FMC of category II – between 40,000 and 80,000 people;

3) FMC of category I – 80,000 people or more.

Health Centers

HC are usually set up in rural areas and subject to their legal form of setup, one may distinguish:

1) Autonomous (public or private) directly contracted by the NHIC;

2) Subdivisions of the aforesaid FMC.

HC are servicing at least 4,500 inhabitants.

HC are classified based on the population size they assist, including that of their FDO and HP as follows:

1) HC of category IV – between 4,500 and 6,000 people;

2) HC of category III – between 6,000 and 9,000 people;

3) HC of category II – between 9,000 and 11,500 people; and

4) HC of category I – 11,500 people and more.

HC as subdivisions of FMC

HC is a subdivision of a district-level FMC that is subordinated to the FMC director, providing basic PHC services to people in a certain location, including to the population assisted by its subdivisions, as prescribed and in the amount set forth in existing bylaws, while ensuring, if needed, the referral of patients further up to the FMC to perform the lab and instrumental investigations it does not have locally. HC is set up in rural areas, preferably located within standardized buildings, equipped with lab facilities, transportation means etc., having a convenient geographic location to ensure easy access for residents from adjacent communities.

The population size covered in a HC location together with all its FDO and HP may not be lower than 4,500 residents. HC is coordinating the work of its FDO and HP.

When streamlining the PHC layout, one has to make allowance for the geographic location, easy access to the HC location, material and technical supplies, and staffing.

Autonomous HC

A HC is autonomous when it complies with the criteria as endorsed by existing bylaws, including when the former presents specific justification, as coordinated with the head of the FMC and/or local public authority (LPA) as to their capacity to operate as autonomous entities.

Autonomous HC is the PHC facility that is set up as per the decision made by LPA and is ensuring basic PHC delivery to people from the respective HC location and surrounding settlements, as per the healthcare delivery agreement concluded with the NHIC, as duly set forth in existing bylaws.

HC, including the autonomous ones, may have a population size under 4,500 given that its geographic location allows easy access of people to healthcare in a designated HC, having informed the MoH first and having submitted justification, coordinated with LPA beforehand.

Autonomous HC may partner up to create associations in order to provide services and/or share certain resources, possibly under the aegis of a FMC.

Family Doctor Offices and Health Posts

FDO and HP are subdivisions of FMC and HC set up in rural areas based on defined criteria.

Streamlining the layout of HC in line with the classification criteria aims at optimizing and streamlining their work, in particular as autonomous entities, towards ensuring direct contracting by the NHIC.

FDO are set up in rural areas with a population size between 901 and about 3,000 inhabitants, with one or two family doctors operating as prescribed by the staffing norms.

HP are set up in rural communities with a population size under 900 inhabitants, with only family medicine nurses operating, as prescribed by the staffing norms.

Whenever two or more communities with HP located within the same coverage area together have a population size between 900 and 1,500 people, they are entitled to one family doctor.

Moldova's coverage with family doctors is 38.8% lower than in the EU. This is one of the factors that impact the quality of healthcare at PHC level undermining people's health status today, in particular, the burden of non-communicable diseases: cardiovascular conditions, diabetes, cancers etc.

There are 1,877 family medicine physicians working all over the country today, caring for about 1,896 people per physician on average. Primary care physicians account for about 15% of all physicians in the Republic of Moldova. The number of PHC nurses is almost three times that of physicians.

Bylaws prescribe 1,500 people per family doctor, as set out in the MoH ordinance no.100 of 10 March 2008 'on Health Staffing Norms'.

Table 4. PHC Professionals (as of January 2012)

Working PHC providers	***Absolute***	***staff per population***
Family doctors	1,877	1,896
Family nurses	5,362	664

CHAPTER II – GLOBAL CONTEXT

2.1 The global burden of mental disorders

Numbers cannot do justice to the pain and suffering caused by mental disorders. Worldwide, 121 million people suffer with depression, 70 million with alcohol-related problems, 24 million with schizophrenia and 37 million with dementia[7]. Until the last decade, however, other health priorities and a lack of sophisticated measures for estimating the burden of mental disorders resulted in the distress of millions of people, their families and careers all over the world going unnoticed.

Several developments have brought the substantial underestimation of the burden of mental disorders to greater public awareness. These include the publication of the "World Development Report: investing in health" (World Bank, 1993) and the development of the disability-adjusted life-year for estimating the global burden of disease, including years lost because of disability (Murray & Lopez, 1996, 2000). According to 2000 estimates, mental and neurological disorders accounted for 12.3% of disability-adjusted life-years, 31% of years lived with disability and 6 of the 20 leading causes of disability worldwide (World Health Report 2001).

It is estimated that the burden of mental disorders will grow in the coming decades. By 2020 mental disorders are likely to account for 15% of disability-adjusted life-years lost. Depression is expected to become the second most important cause of disability in the world (Murray & Lopez, 1996). Developing countries with poorly developed mental health care systems are likely to see the most substantial increases in the burden attributable to mental disorders. The impressive reductions in rates of infant mortality and infectious diseases, especially in developing countries, will result in greater numbers of people reaching the age of vulnerability to mental disorders. The life expectancies of people with mental disorders can be expected to increase, and gradual gains in life expectancy can be expected to result in increasing numbers of older people suffering from depression and dementia.

Other possible reasons for the increase in the burden of mental disorders include rapid urbanization, conflicts, disasters and macroeconomic changes. Urbanization, homelessness,

[7] World Health Organization (2003) Mental Health Policy and Service Guidance Package – The Mental Health Context. World Health Organization

poverty, overcrowding, pollution, disruption in family structures and loss of social support, are well-recognized risk factors for mental disorders (Desjarlais et al., 1995). Rising numbers of people all over the world are exposed to armed conflicts, civil unrest and disasters, leading to displacement, homelessness and poverty. People exposed to violence are more likely than others to suffer from mental disorders such as post-traumatic stress disorder and depression, possibly leading to drug and alcohol abuse and increased rates of suicide (World health report, 2001).

The burden of mental disorders is maximal in young adults, the most productive section of the population. Developing countries are likely to see a disproportionately large increase in the burden attributable to mental disorders in the coming decades. People with mental disorders face stigma and discrimination in all parts of the world. The burden of mental disorders does not uniformly affect all sections of society. Groups with adverse circumstances and the least resources face the highest burden of vulnerability to mental disorders.

Different vulnerable groups may be affected by the same problems. Members of these groups are more likely than other people to be unemployed, to face stigmatization and to suffer violations of their human rights. They also face significant access barriers, e.g. with regard to the availability and cost of treatment of satisfactory quality for their mental disorders. Negative stereotyping and bias among health providers further reduces the likelihood of receiving appropriate attention for their mental health needs (Cole et al., 1995; Shi, 1999).

Mental health services are widely underfunded, especially in developing countries. Nearly 28% of countries do not have separate budgets for mental health. Of the countries that have such budgets, 37% spend less than 1% of their health budgets on mental health. Expenditure on mental health amounts to under 1% of the health budgets in 62% of developing countries and 16% of developed countries.[8] Thus there is a significant discrepancy between the burden of mental disorders and the resources dedicated to mental health services.

2.2 Global health reform trends and implications for mental health

The last 30 years have seen major reforms in the general health sector and the mental health sector. Decentralization and health financing reforms are the two key changes that have

[8] World Health Organization (2003) Mental Health Policy and Service Guidance Package – Organization of Services for Mental Health. World Health Organization

affected general health care systems. These issues are important for mental health because there is an increasing awareness of the need for adequate funding of mental health services and an emphasis on integrating these services into general health care systems.

Decentralization is the transfer of responsibility for health service provision from central to local government structures (Cassels, 1995). Before the implementation of this process, health systems were largely public structures administered directly by central government health departments. Central government was therefore responsible for the financing, policy implementation, regulation, and operation of services at the tertiary, secondary and primary levels of health systems.

Decentralization began in the industrialized countries and has proceeded to influence the shape of systems in developing nations. The decentralization of public health services to the local government level has been rapidly adopted by developing countries for a number of reasons. These include: changes in internal economic and political systems in response to the pressures of economic globalization; the perception that services planned in accordance with local needs can more appropriately address them; disruptions of systems caused by civil disturbances and population displacements.

Health sector reforms provide a number of opportunities for mental health services but also carry significant risks. In a rational decision-making process the obvious burden of mental health and the availability of effective interventions should lead to an increased provision of financial and human resources for promotion, prevention, treatment and rehabilitation in the field of mental health. A reforming health system provides the opportunity to redirect available resources towards mental health even in circumstances where the total health resources are constant.

Health sector reforms also provide an opportunity to integrate mental health services into general health care, especially at the primary care level. Integration with primary care increases the possibility of universal coverage (including mental health) without a substantial increase in financial and administrative inputs. Integrated care helps to reduce the stigma associated with seeking help from stand-alone mental health services.

Decentralization also carries a risk of fragmentation and duplication of services, with the result that resources are used inefficiently because of a lack of economies of scale.

These risks should therefore be taken into account in connection with the process of decentralization. Countries should carefully consider whether it is feasible for them to implement

a decentralization strategy in the presence of the risks. Physical and human resources for mental health should be available in the regions concerned if decentralization is to succeed.

One way of ensuring this at the national level is to specify both the minimum level of services for mental health to be provided by local decentralized regions and the proportion of the total health budget to be dedicated to mental health. Investment should also be made in the training of personnel in order to enable planning, management and budgeting for mental health services.

2.3 Mental Health and Human Rights.

Mental health legislation is necessary for protecting the rights of people with mental disorders, who are a vulnerable section of society. They face stigma, discrimination and marginalization in all societies, and this increases the likelihood that their human rights will be violated. Mental disorders can sometimes affect people's decision-making capacities and they may not always seek or accept treatment for their problems. Rarely, people with mental disorders may pose a risk to themselves and others because of impaired decision-making abilities. The risk of violence or harm associated with mental disorders is relatively small. Common misconceptions on this matter should not be allowed to influence mental health legislation.

Mental health legislation can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of care of high quality, the improvement of access to care, the protection of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment. Legislation can also play an important role in promoting mental health and preventing mental disorders. Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services.

According to the Mental Health Policy and Service Guidance Package, Mental Health Legislation and Human Rights (2005, WHO), there is no national mental health legislation in 25% of countries with nearly 31% of the world's population, although countries with a federal system of governance may have state mental health laws. Of the countries in which there is mental health legislation, half have national laws that were passed after 1990. Around 15% have legislation that was enacted before 1960, i.e. before most of the currently used treatment modalities became available (World Health Organization, 2001). The existence of mental health legislation does not necessarily guarantee the protection of the human rights of people with

mental disorders. In some countries, indeed, mental health legislation contains provisions that lead to the violation of human rights.

Mental health legislation is essential to complement and reinforce mental health policy and is not a substitute for it. It provides a legal framework ensuring the consideration of critical issues such as access to mental health care, the provision of care that is humane and of high quality, rehabilitation and aftercare, the full integration of persons with mental disorders into the community and the promotion of mental health in different sectors of society.

Among the key aspects of the interface between policy and legislation are the following.

1. Human rights. Human rights should be an integral dimension of the design, implementation, monitoring and evaluation of mental health policies and programmes. They include, but are not limited to, the rights to: equality and non-discrimination; dignity and respect; privacy and individual autonomy; and information and participation. Mental health legislation is a tool for codifying and consolidating these fundamental values and principles of mental health policy.

2. This is important in nearly all countries that have recently developed or revised their mental health policies. Legislation can ensure that involuntary admission is restricted to rare situations in which individuals pose a threat to themselves and/or others and community based alternatives are considered unfeasible. It can therefore create incentives for the development of a range of community-based facilities and services. The restriction of involuntary admission to a limited period of time, usually months rather than years, creates further incentives for community-based care and rehabilitation. Legislation allows people with mental disorders and their families and carers to play an important role in interactions with mental health services, including admission to mental health facilities.

3. Links with other sectors. Legislation can prevent discrimination against persons with mental disorders in the area of employment. Examples include protection from dismissal on account of mental disorders and affirmative action programmes to improve access to paid employment. With regard to housing, legislation can improve access by preventing the geographical segregation of persons with mental disorders and mandating local authorities to provide subsidized housing to people disabled by such disorders. Legislation on disability pensions can also promote equity and fairness.

4. Enhancing the quality of care. Legislative provisions on general living conditions and

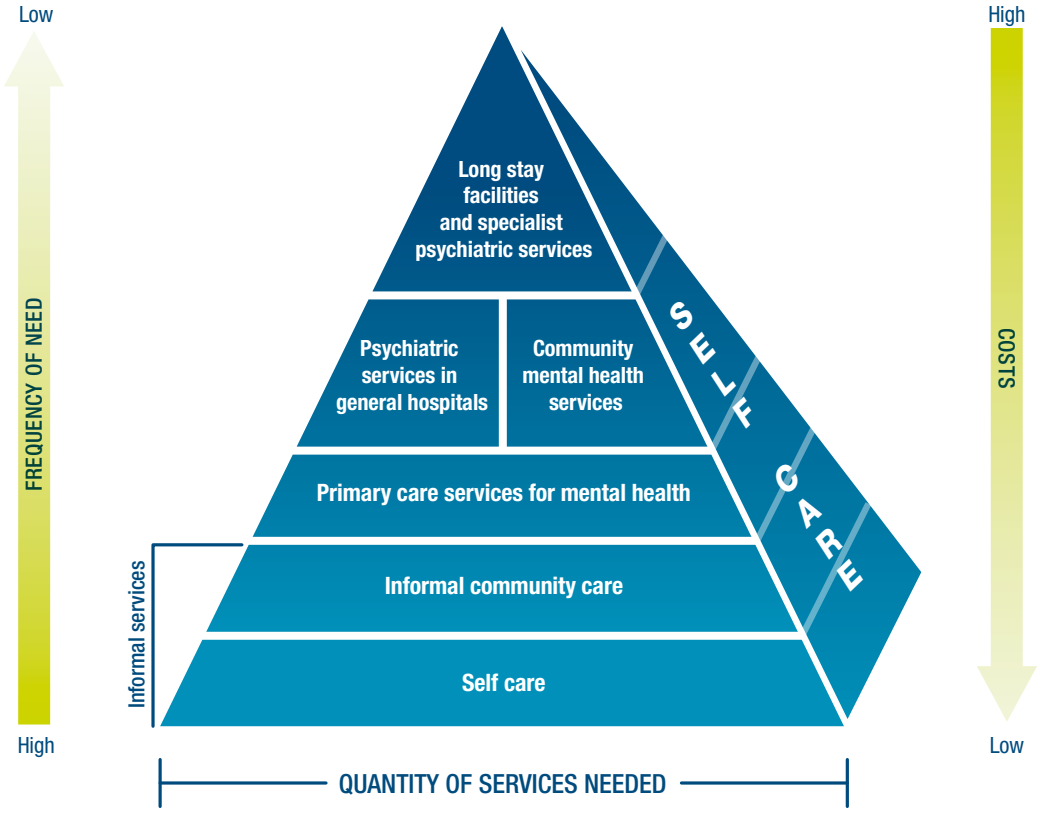
protection against inhuman and degrading treatment can lead to significant improvements in the built environment of mental health facilities. Legislation can set minimum standards in respect of treatment and living conditions for the accreditation of mental health facilities. It can lay down minimum qualifications and skills for the accreditation of mental health professionals, thus ensuring that a basic minimum level of expertise is provided throughout the country in question. It can also set minimum staffing standards for the accreditation of mental health facilities and can therefore act as a major incentive for investment in the development of human resources.

2.4 Mental Health Services in international context.

Very few countries have an optimal mix of services. Some developing countries have made mental health services more widely available by integrating them into primary care services. Other countries have also made mental health services available at general hospitals. In some countries there are good examples of intersectoral collaboration between non-governmental organizations, academic institutions, public sector health services, informal mental health services and users, leading to the development of community-based services. Even within countries there are usually significant disparities between different regions, and both types of service are only available to small proportions of populations, usually in urban areas or selected rural areas.

In developed countries the process of deinstitutionalization during the last three decades has led to reductions in the populations of mental hospitals and to the closure of many of these institutions. However, this has not been accompanied by sufficient provision of community-based services, which are often inadequate and unevenly distributed. There is insufficient emphasis on developing mental health services in primary care. For example, although depression is a common problem in primary care settings, it is still not identified or is undertreated by primary care practitioners in many developed countries.

In the figure 1 we can find the optimal mix of services for mental health proposed by the World Health Organization in 2007.



World Health Organisation service organisation pyramid for an optimal mix of services for mental health (2007)

The various components of mental health services are categorized below. This is not a recommendation on the organization of services, but an attempt to broadly map the services that exist[9].

I) Mental health services integrated into the general health system can be as broadly grouped as those in primary care and those in general hospitals.

Mental health services in primary care include treatment services and preventive and promotional activities delivered by primary care professionals. Among them, for example, are services provided by general practitioners, nurses and other health staff based in primary care clinics. Primary care services are easily accessible and are generally better accepted than other forms of service delivery by persons with mental health disorders. This is mainly attributable to the reduced stigma associated with seeking help from such services. Both providers and users generally find these services inexpensive in comparison with other mental health services.

[9] World Health Organization (2003) Mental Health Policy and Service Guidance Package – Organization of services for Mental Health. World Health Organization

Mental health services in general hospitals include services offered in district general hospitals and academic or central hospitals that form part of the general health system. Such services include psychiatric inpatient wards, psychiatric beds in general wards and emergency departments, and outpatient clinics. There may also be some specialist services, e.g. for the children, the adolescents and the elderly. The clinical outcomes associated with these services are variable and depend on their quality and quantity. In many countries, the mental health services of general hospitals can manage acute behavioural emergencies and episodic disorders that require only outpatient treatment. Mental health services based in general hospitals are usually well accepted. Because general hospitals are usually located in large urban centres, however, there may be problems of accessibility in countries lacking good transport systems.

II) Community mental health services can be categorized as formal and informal.

Formal community mental health services include community-based rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, home help and support services, and community-based services for special populations such as trauma victims, children, adolescents and the elderly. Community mental health services are not based in hospital settings but need close links with general hospitals and mental hospitals. They work best if closely linked with primary care services and informal care providers working in the community.

Well-resourced and well-funded community mental health services provide an opportunity for many persons with severe mental disorders to continue living in the community and thus promote community integration. High levels of satisfaction with community mental health services are associated with their accessibility, a reduced level of stigma associated with help seeking for mental disorders and a reduced likelihood of violations of human rights.

Informal community mental health services may be provided by local community members other than general health professionals or dedicated mental health professionals and paraprofessionals. Informal providers are unlikely to form the core of mental health service provision and countries would be ill advised to depend solely on their services, which, however, are a useful complement to formal mental health services and can be important in improving the outcomes of persons with mental disorders.

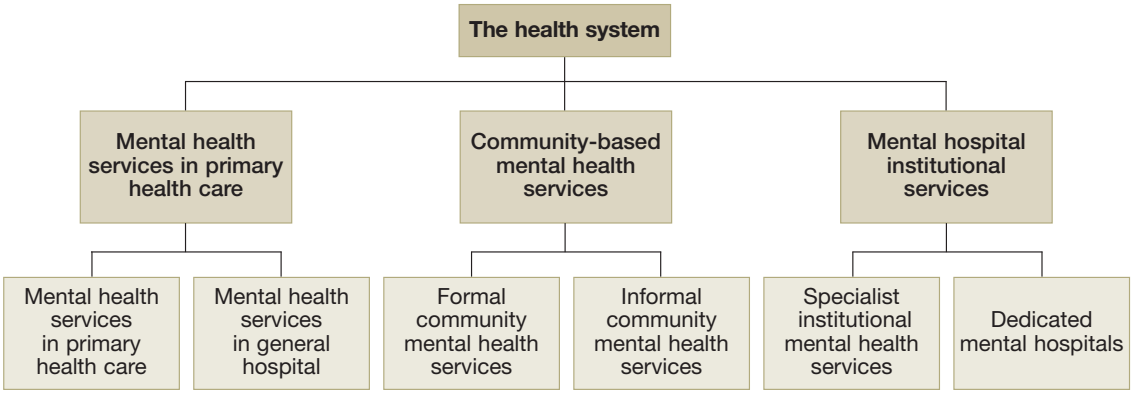
III) Institutional mental health services include specialist institutional services and mental hospitals. A key feature of these services is the independent stand-alone service style, although they may have some links with the rest of the health care system.

Specialist institutional mental health services are provided by certain outpatient clinics and by certain public or private hospital-based facilities that offer various services in inpatient wards, such as acute and high security units, units for children and elderly people, and forensic psychiatry units.

Dedicated mental hospitals mainly provide long-stay custodial services. In many parts of the world they are either the only mental health services or remain a substantial component of such services. In many countries they consume most of the available human and financial resources for mental health. This is a serious barrier to the development of alternative community-based mental health services. Mental hospitals are frequently associated with poor outcomes attributable to a combination of factors such as poor clinical care, violations of human rights, the nature of institutionalized care and a lack of rehabilitative activities. They therefore represent the least desirable use of scarce financial resources available for mental health services. This is particularly true in those developing countries where mental hospitals provide the only mental health services. Stigma associated with mental hospitals also reduces their acceptability and accessibility.

A schematic representation of different components of mental health services found across the world is given in Figure 2. The framework aims to broadly map the variety of services in different countries with varying health systems and varying levels of care provision. It is not a recommendation on organization but an attempt to describe various types of services.

Fig. 2. Components of mental health services



CHAPTER III – OBJECTIVES AND METHODOLOGY

3.1 Objectives of the study:

- *To assess the individual needs of beneficiaries and their degree of autonomy within residential care facilities for the planning of mental health system reforms and deinstitutionalization in the Republic of Moldova.*

Specific Goals:

1. To evaluate the degree of autonomy of the patients living in psychiatric hospital and psycho-neurological boarding houses;
2. To evaluate the 4 psycho-neurological boarding houses for adults and the 3 psychiatric hospitals;
3. To develop recommendations for the deinstitutionalization plan for people with mental health problems and community placement, based on the study findings.

3.2 Methodology

3.2.1. Design of the study

This is a cross-sectional survey aimed at determining the level of autonomy of patients to leave independently in community from all mental health services in Moldova. This study was provided in a defined population, namely 10 % of all residents of psychiatric hospitals and residential institutions at a *particular point in time (summer 2013)*.

3.2.2. Sampling

It was computed based on a 10 per cent representation (this was the requirement from ministries) of residents, as follows (tab. 5):

Table 5. Sampling: number of beneficiaries from institutions.

No.	Name of facility	Total number of residents[10]	Sample
1	PNBH, Balti	548[11]	55
2	PNBH, Branzeni, Edinet	311	31

[10] Social Report 2011 data, source: http://mpsfc.gov.md/md/rapoarte/

[11] Study: The system of guardianship in practice in the Republic of Moldova: Human Rights and Vulnerability of Persons Declared Incapacitated, OHCHR, Chisinau 2013

3	PNBH, Badiceni, Soroca	463	46
4	PNBH, Cocieri, Dubasari	365	37
5	CPH Costiujeni, Chisinau (960 beds, of which 150 people in coercive treatment or children)	710[12]	71
6	PH, Balti (670 beds, of which 70 for children)	600	60
7	TB and PH, Orhei	180	20
	Total:	**3177**	**320**

Criteria for the selection of respondents:

- Beneficiaries were selected randomly – each tenth person from the general roster of beneficiaries from the respective facility selected for individual assessment;
- One shall disregard one's age or diagnosis, as the questionnaire includes data on mental and intellectual disability, and one's physical status alike;
- It enabled us to draw conclusions as to one's severity of disability and need for any additional care required.

3.2.3. Implementation of the study

The implementation team was made up of experienced and trained national experts, who advocated for the individual assessment tool in target facilities.

Stage 1. Team members were trained from 27-31 May 2013. The training included an introduction to the study and specially to the assessment tools, followed by a piloting of 67 questionnaires in three different MH facilities, aiming to evaluate the implementation issues in each type of facility: *CPH Chisinau (30)* and ***PNBH in Cocieri, Dubăsari (37).***

Stage 2. The team conducted the interviews from 3-18 June 2013 (administering another ***253*** questionnaires);

Stage 3. Data was processed, checked and pre-analysed from 18-30 July 2013;

Stage 4. Consultation with national and international experts (MH Foundation, UK) regarding data processing and presentation in a comprehensive and useful report.

Tab. 6. Timeframe for facility assessments**:**

No.	Name of Facility	27.05	28.05	29.05	30.05	3.06	4.06	5.06	6.06	7.06	10.06	11.06	12.06	14.06	15.06	17.06
1	PNBH, Balti										+	+			+	+
2	PNBH, Branzeni												+			

[12] Profile of inpatient beds, source: MoH 2013

3	PNBH, Badiceni												+		
4	PNBH, Cocieri			+	+											
5	CPH Costiujeni	+	+			+	+	+	+							
6	PH, Balti							+	+	+	+	+				
7	PH, Orhei															

3.2.4. Tools and procedures

A. Individual assessment

A questionnaire was developed aiming to assess patients receiving care or support from a mental health facility. It evaluates information about the support needed from the resident's point of view. The questionnaire had both quantitative and qualitative data and was designed to be filled in by the patient and anyone else who might want to get involved – family 'members, friends and carers from institution.

The assessment questionnaire was developed to account for patient's individual needs. It was adapted from the assessment tool used in a study[13] conducted by the Mental Health Foundation (UK) and the Trimbos Institute (Netherlands), in collaboration with WHO/Europe and national experts from Turkey, for the Ministry of Health and the Ministry of Family and Social Policy of Turkey.

The questionnaire combines the following key elements:

a. General section: personal data and details about patients/residents, including age, gender, residence, marital and social status, occupation, diagnosis, number of hospitalizations, any disability, length of stay, time of illness etc.;
b. Health section, listing all general and mental health issues and shortcomings, and any need for medication;
c. Section on the assessment of self-directed support and control

Conducting the assessment

The team of national experts undertook visits to target facilities, having secured first a letter of support from the MoH and MoLSPF and having informed the agreed facilities about the upcoming visits beforehand. Assessment questionnaires were filled out by the patients / residents randomly selected during the visit on an "each tenth on the roster" basis in each facility. Interviews were conducted at a location pre-set by physicians or nurses, or in a respondent friendly environment.

[13] http://www.mentalhealth.org.uk/our-work/research/evaluation-integrated-residential-model-people-complex-needs/?view=Standard

The questionnaire was filled in together with the respondent to make sure the latter is involved in the process and to make best use of accurate data. Following the interview, some data, such as date of birth, diagnosis, length of stay etc., were crosschecked against available files.

Collection of survey data:

- Respondent accounts were the main source of information;
- People knowing best the respondents, such as roommates or staff, were interviewed as well;
- Interviewers used observation as a means to get more accurate data;
- Records were reviewed, as needed, to double-check and clarify data;
- Before being interviewed, respondents were explained the purpose of the study, while also asking for their consent. After and only after they agreed to participate in the assessment, people were asked to sign a written consent before proceeding with the survey per se. All collected data shall have no personal information and shall be confidential!

Scoring for the level of support

There are 38-40 questions to be checked in order to assess one's level of required support (to add up to any **other** points).

If a person scores 40, it means he/she can cope with daily tasks on his/her own, and no support from others is required.

If a person scores between 41 and 85, that means it needs occasional support (1-2 times a month).

If a person scores between 86 and 134, that means it requires regular support (3-5 times a week).

If a person scores between 135 and 178, that means it requires constant support.

B. Institutional assessment tool

The facilities targeted by this study differ significantly across in terms of service setup, purpose and type of activities they provide and this needs assessment focuses on the services provided by the psychiatric hospitals subordinate to the MoH, and by residential care facilities (psycho-neurological boarding houses) for the people with mental disabilities, subordinate to the MoLSPF. It was agreed to separately assess residential care facilities and psychiatric care hospitals, with subsequent integration of data for cross-comparison.

The tool was designed as a simple way of aggregating expert opinions about a facility based on a "traffic light" scoring.

- A global approach is used to attribute a “traffic light” score;
- Emphasis is mainly put on facility adequacy / appropriateness and safety for the patients in order to maximize their health status, wellbeing and social functionality.

In order to appraise someone’s score, focus shall be on the potential impact – be it positive or negative – that a facility exerts on a patient:

- *Minor impact* - insignificant influence, slightly below the ideal situation without any impact, on care, environment or regimen, while the problem may be easily sorted out within the current institutional setup. It might get a “green” score, unless experts have other concerns that could make them give an “amber” score;
- *Moderate* impact - Gaps in care, environment or regimen, influencing considerably or potentially significantly one’s health status, safety or wellbeing, or the risk of their occurrence;
- *Major impact* - Any deficiency exerting a severe or lengthy influence on a patient’s health status, safety or wellbeing. It invariably gets a “red” score.

One may interpret the “traffic light” score as follows:

- **Red**: It is indicative of serious concerns / severe shortcomings, which either significantly worsen the condition or the physical or psychological integrity of service users, or lower the quality or the outcomes of treatment or care being rendered in any particular facility.
- **Amber**: There are some concerns, and there is space for improvement; however, there are no immediate critical risks noticed to service users or to the quality or treatment outcomes. Any reported gaps might have a minor impact only, or a moderate one, at most.
- **Green**: It is in full compliance or beyond expectations.

The tool consists of the following sections:

- Information and involvement of residents;
- Individual care;
- Safety;
- Staffing levels

The section on informed consent was filled out with consideration given to the key issue, i.e. one's consenting to treatment having ascertained a respondent's capacity to consent in the first place.

Questions on family involvement were raised with staff, as respondent was also asked similar questions during individual interviews.

Regarding one's nutrition, basic needs and wellbeing, which are cross-related, experts were have to resort to observation and get appropriately involved in the work of the facility (e.g., looking into their practices, not just clinical treatment), in order to assess to what degree the basic needs of service users are met.

The section on meaningful activities should consider occupational activities

The chapter on the management of difficult behaviours was focused on a balanced approach to global issues: for instance, is isolation or constraint used excessively are they humane process-wise. Both are important, but overuse of isolation or constraints is in itself an indication of poor quality, irrespective whether the process or rules are appropriate.

The goal of assessing human resources is to get a snapshot of the actual labor force at facility level. It focuses on an overall assessment of labor force, as we are not attempting to evaluate the qualifications and skills of individual personnel or staff groups.

Partly, information shall be drawn from the statistical data on the number and types of different roles and activities; the other part of missing information shall be unveiled through observation and informal discussions with personnel.

CHAPTER IV - RESULTS

4.1 Findings of the assessment of psycho-neurological boarding house residents

The assessment was performed within the four PNBH of the Republic of Moldova. There were 169 residents enrolled overall in the survey, with the following distribution (*Figure 4.1.1*):

- PNBH Badiceni – 46 respondents, or 27.2 per cent;
- PNBH Balti – 55 respondents, or 32.5 per cent;
- PNBH Branzeni – 31 respondents, or 18.3 per cent;
- PNBH Cocieri – 37 respondents, or 21.9 per cent.

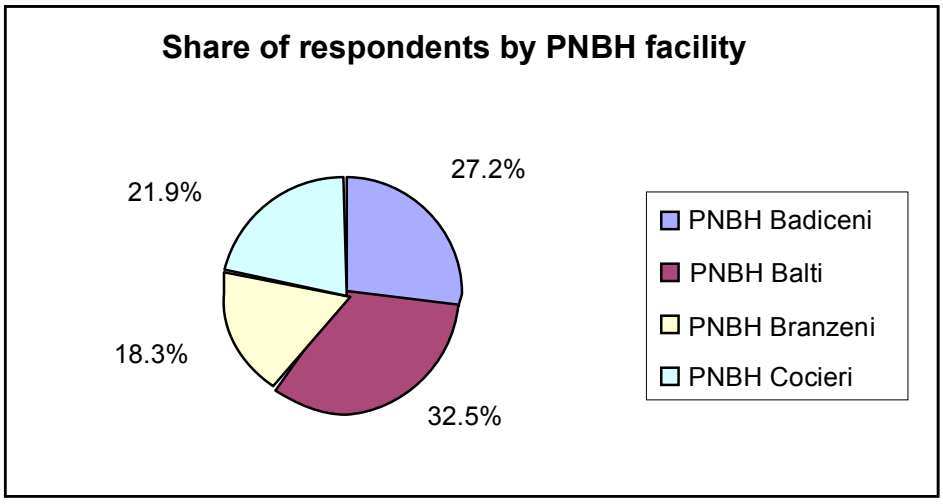


Figure 4.1.1 Distribution of respondents by PNBH

Presented below is a review of data collected from the PNBH residents on *section 1 "Personal Details"* (*see Annex 1 "Individual Assessment Tool for the Residents of MH Facilities"*):

- Regarding the respondents, 89 were women (52.7%), and 80 were men (47.3%), whit an average age of 47.61 years (ranging between 15 and 81 years).

- PNBH respondents reported to have had a history of 1 to 40 admissions to different mental health facilities over time. Approximately 12% of all respondents have been admitted for residential care 1-3 times.

- The reason for admitting a respondent to a PNBH was assessed through three different sources of data: patient charts, the respondent himself/herself, and the PNBH staff (if the first two sources of data were unavailable).

The analysis of data from the medical records indicated that:

- 67.5% of all PNBH respondents were admitted due to continuous need for care, while 8.9% claimed to have been admitted after being referred by the MoLSPF,

- 5.3% were admitted because they had no relatives, and

- another 5.3% due to some deficiencies (*Figure 4.1.2*).

- Moreover, a small share of respondents (3.6%) were admitted because they were presenting some sort of disability, or a mental health condition/homelessness (1,8%), and 1.2% have been transferred from another boarding house. The reason of admission was not known for 1.8% of respondents.

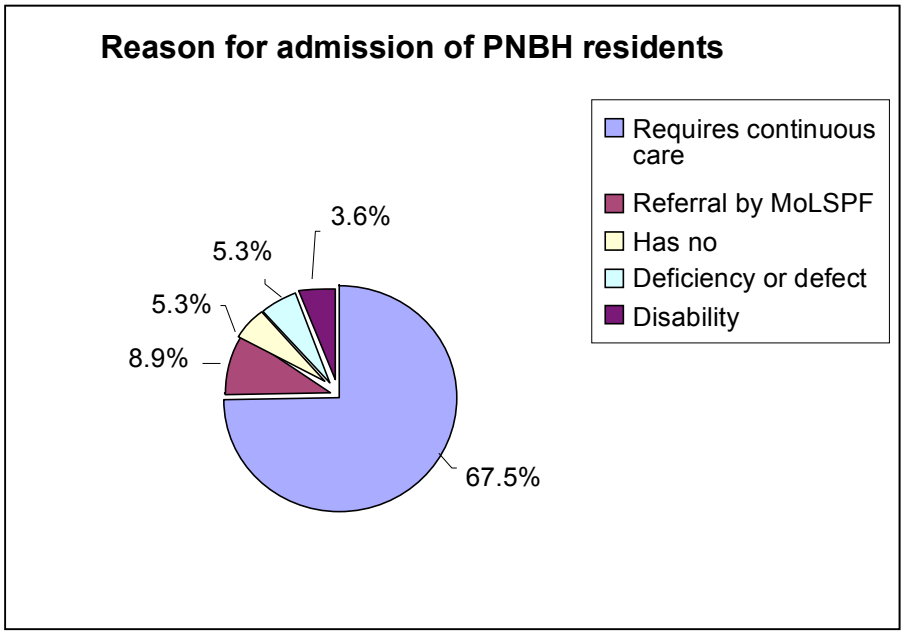


Figure 4.1.2 Reasons for admission of PNBH respondents (as per the patient charts)

It was much more difficult to review the reason for admission based on the residents' own accounts, as:

- 44.4% of respondents failed to answer the question, while 14.2% said they ignored the reason for being there.
- Only 41.4% of all respondents were able to give the reason for admission, as follows: worsening of clinical condition (9,5%), absence of relatives (7.1%), difficulties with relatives or neighbours (4,1%), being brought in by a relative (3,6%) and lack of support from relatives (3.6%) (*Figure 4.1.3*).

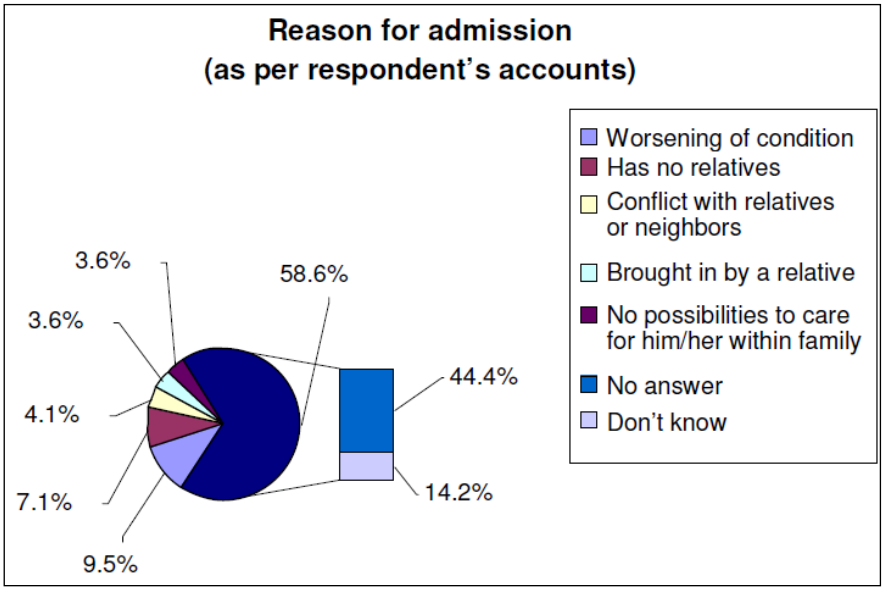


Figure 4.1.3 Reason for admission of PNBH residents (as per the respondent's own accounts)

Cumulative duration of stay in different facilities for the PNBH residents ranged between 1 and 63 years, whereas 17.2% of the total number of respondents could not answer that question. Cumulative duration of sickness ranged between 5 and 79 years, averaging 33.72 years. A cross-comparison of the above two indicators revealed that basically most of the time a person was living with a mental health problem has been spent in a facility.

No formal education was reported by almost half of evaluated respondents, primary education was reported by 21.3%, incomplete secondary education and general secondary education – 10.7% each, specialized secondary education – 5.9%, and only 2 respondents, or 1.2%, stated to have higher education.

A disability degree was reported by 95.9% of PNBH interviewees; 71% had 2nd degree disability, 24.3% had 1st degree disability, and 0.7% had 3rd degree disability (*Figure 4.1.4*).

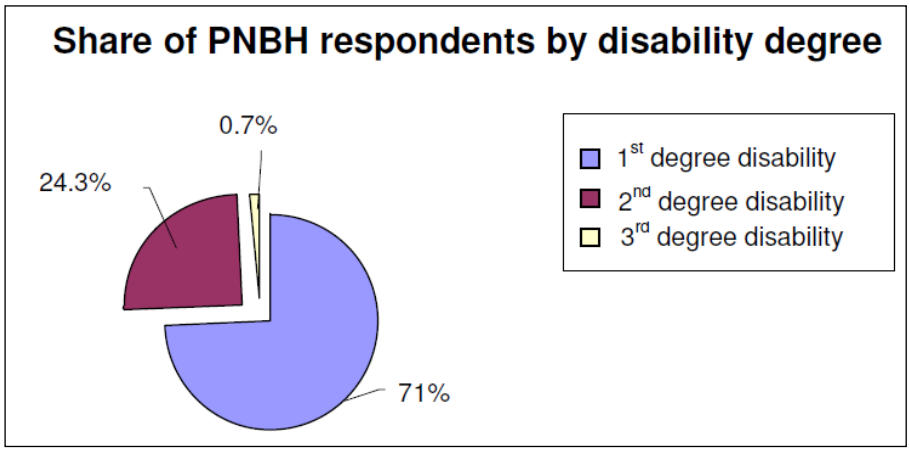


Fig. 4.1.4 Distribution of PNBH respondents by disability degree

However, despite having disability degrees, of the 169 respondents that were interviewed, 104 had no guardian (61.5%), whereas 63 of PNBH residents, accounting for 37.3% of them, had a guardian, i.e. were deprived of legal capacity.

Forty-two per cent of them reported to have a family, while the remaining 58% stated to have none. Only one-quarter of respondents reported to have been visiting or visited by their families (i.e., 24.3%). Yet, 106 respondents (62.7) denied to have had visits to each other with their families. As few as 22.5% had a regular contact with their family or relatives, while 64.5% reported not to regularly contact with the family, and 13% couldn't say.

Presented below is a review of data collected from the PNBH residents on section 2 "Health" *(see Annex 1 "Individual Assessment Tool for the Residents of MH Facilities"*.

If one is to distribute the above 169 study PNBH respondents by intellectual disability and mental health problems, one may get the following picture: 121 (71.6%) presented with intellectual disabilities, , while another 56 people presented with mental health problems (33.1%) (*Figure 4.1.5*). Listed in the *Table 4.1.1* are the incidence and types of intellectual disabilities of PNBH respondents enrolled in the study, as follows.

Table 4.1.1 Distribution of PNBH respondents by intellectual disability

- Epilepsy	- 14 individuals	- 9.6%
- Down syndrome	- 5 individuals	- 3.4%
- Cerebral Palsy	- 15 individuals	- 10.3%
- Acquired cerebral trauma	- 4 individuals	- 2.7%
- Mental retardation	- 104 individuals	- 71.2%
- Dementia	- 4 individuals	- 2.7%

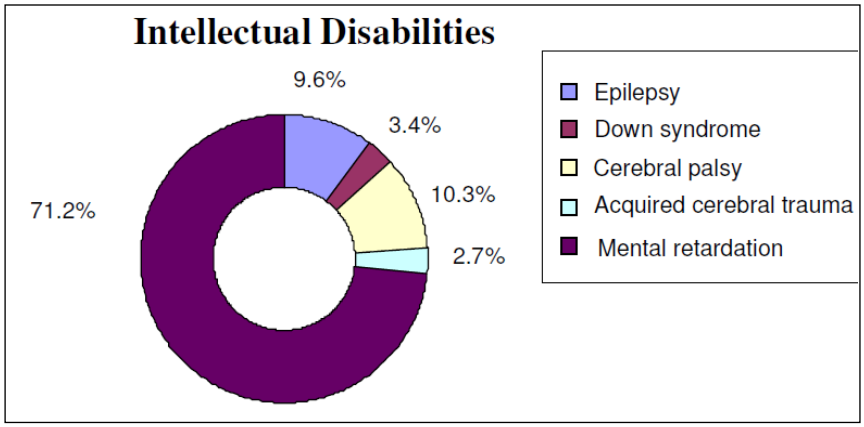


Figure 4.1.5 Distribution of PNBH respondents by intellectual disability

Listed in the *Table 4.1.2* below are the MH problems of the 56 respondents interviewed, as also outlined in *Figure 4.1.6*.

Table 4.1.2 Distribution of PNBH respondents by mental health problems

- Schizophrenia / other psychoses	- 48	- 85.7%
- Bipolar disorders	- 7	- 12.5%
- Personality disorders	- 1	- 1.8%

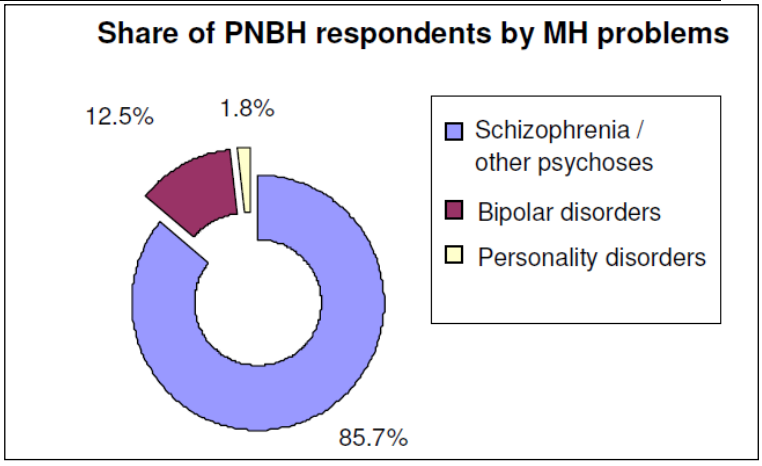


Figure 4.1.6 Distribution of PNBH respondents by MH problems

Within this study, respondents (169) were assessed in terms of difficulties they were facing day in, day out, as follows:

a) Difficult behaviours displayed by 49 respondents (29%);
b) Difficulty in using verbal language was reported by 40 people (23.7%);
c) Anxiety was reported by 14 people (8.3%);
d) Aggressive conduct was displayed by 36 respondents (21.3%);
e) Locomotor problems were reported by 17 respondents (10.1%);
f) Confusion was reported by 9 people (5.3%);
g) Disorientation to time, space and person was found in 8 people (4.7%); and
h) Hallucinations and deliria were reported by 38 respondents (22.5%)

Besides mental health problems and disabilities, PNBH residents reported, some general medical conditions, complicating furthermore their functions. Listed below are some of those: low/high blood pressure – 30 people (21.1%), hepatitis – 19 people (13.4%), heart conditions – 18 people (12.7%), lung conditions – 16 patients (11.3%), gastrointestinal disorders – 12 people (8.5%), eye conditions – 10 people (7.0%), TB – 8 respondents (5.6%), trauma – 7 respondents (4.9%), blood conditions – 6 respondents (4.2%), and genitourinary conditions – 5 individuals (3.5%) (*Figure 4.1.7*)

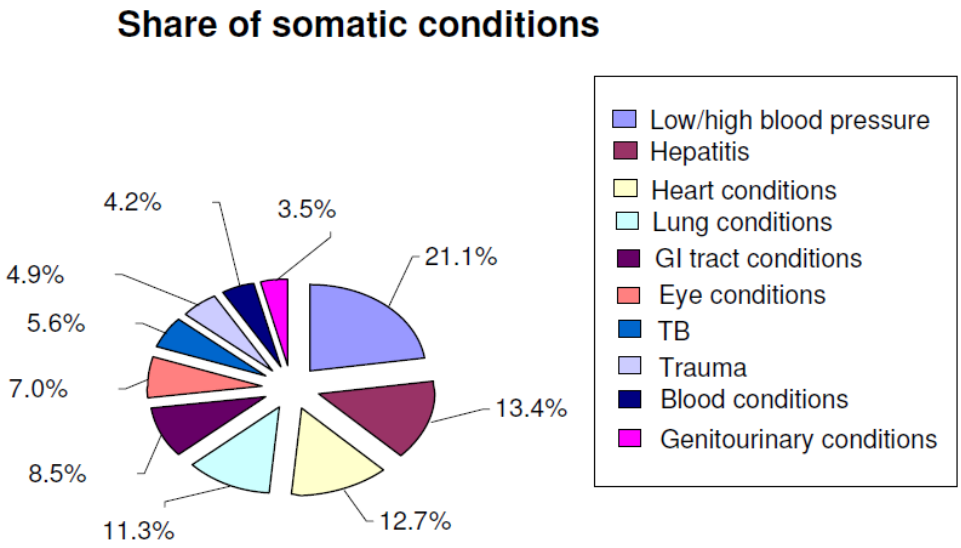


Figure 4.1.7 Distribution of PNBH respondents by somatic conditions

Support therapy was needed by 78 residents, or 46.2%; 91 respondents, or 53.8%, required no support medication.

The study revealed locomotor problems in some of those 169 PNBH respondents. A mere 14.8% of respondents, i.e. 25 persons, required locomotor support, whereas the remaining 85.2% (144) had no locomotor support needs. Almost all respondents (99.4%) had no special diet needs.

The survey of 169 PNBH respondents outlined that:

- ***4.1% of them were self-sufficient;***
- ***58% required occasional support (98 respondents);***
- ***36.7% of them required regular support (62 respondents);***
- ***1.2% of them were fully dependent (2 respondents) (Figure 4.8)***

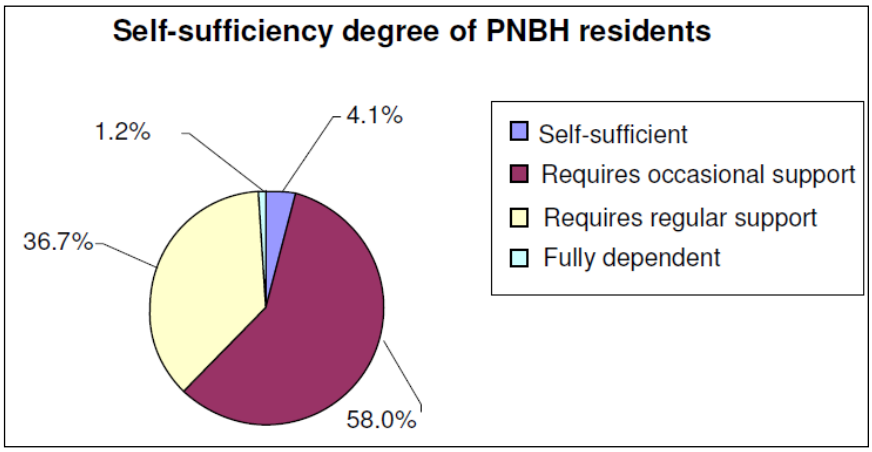


Figure 5.1.8 Self-sufficiency of PNBH respondents

4.2 Findings of the assessment of psychiatric hospital residents

There were 152 respondents in the study from among the residents of the three psychiatric hospitals in the Republic of Moldova, as follows (*Figure 4.2.1*):

a. CPH – 71 respondents, or 46.7%;
b. PH Balti – 61 respondents, or 40.1%; and
c. PH Orhei – 20 respondents, or 13.2%

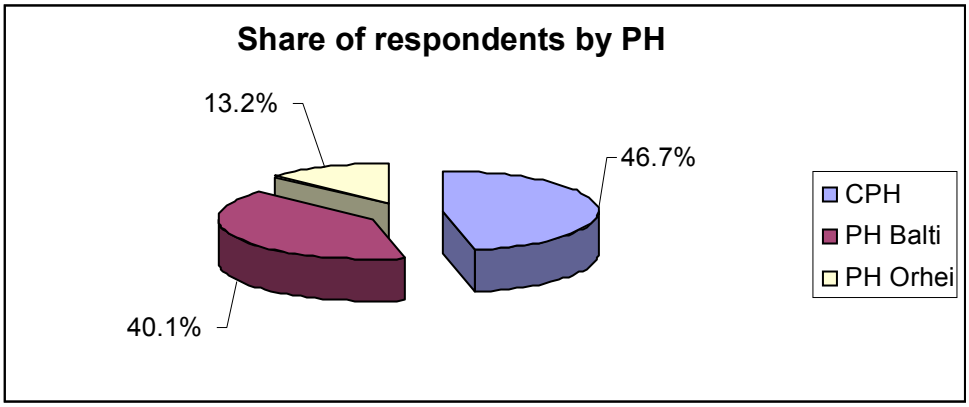


Figure 4.2.1 Distribution of respondents by PH

Presented below is a review of data collected from the PH respondents residents on *section 1 "Personal Details"* (*see Annex 1 "Individual Assessment Tool for the Residents of MH Facilities"*).

- The respondents enrolled in this survey were men and women, with the following distribution: 79 were women, accounting for 52%, and 73 were men, or 48%, while the age of respondents ranged between 18 and 81 years, averaging 47.53 years.
- PH respondents reported to have had a history of 1 to 200 to different mental health facilities over time. Approximately 13.8% of all respondents have been admitted for residential care at least once.
- The reason for admitting a PH respondent was assessed by using three different sources of data: patient chart, the respondent himself/herself, and PH staff, if the first two sources of data would not suffice.
- The analysis of data from the medical records suggests that 99.3% of all respondents were admitted because of a worsening condition, while the reason of admission was not indicated in 0.7% of medical records (*Figure 4.2.2*).

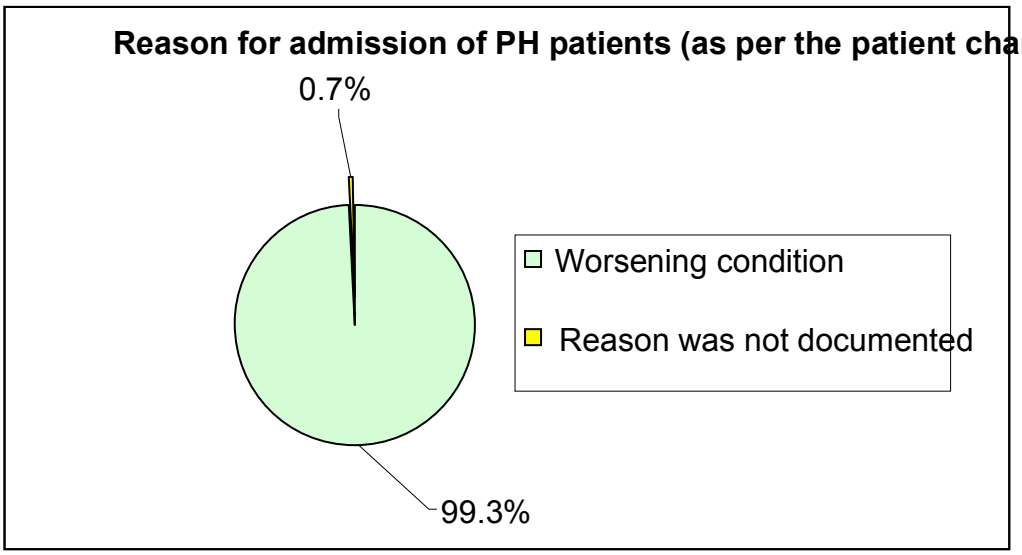


Figure 4.2.2 Reason for admission of PH patients (patient charts)

It was not difficult to review the reason for the admission of PH patients, as only 10.5% of all respondents failed to tell, while 47.4% of all respondents cited as a reason the worsening of their psychiatric condition, 25% stated they got into a conflict with relatives or neighbours, 7.2% mentioned a worsening of a somatic condition (*Figure 4.2.3*).

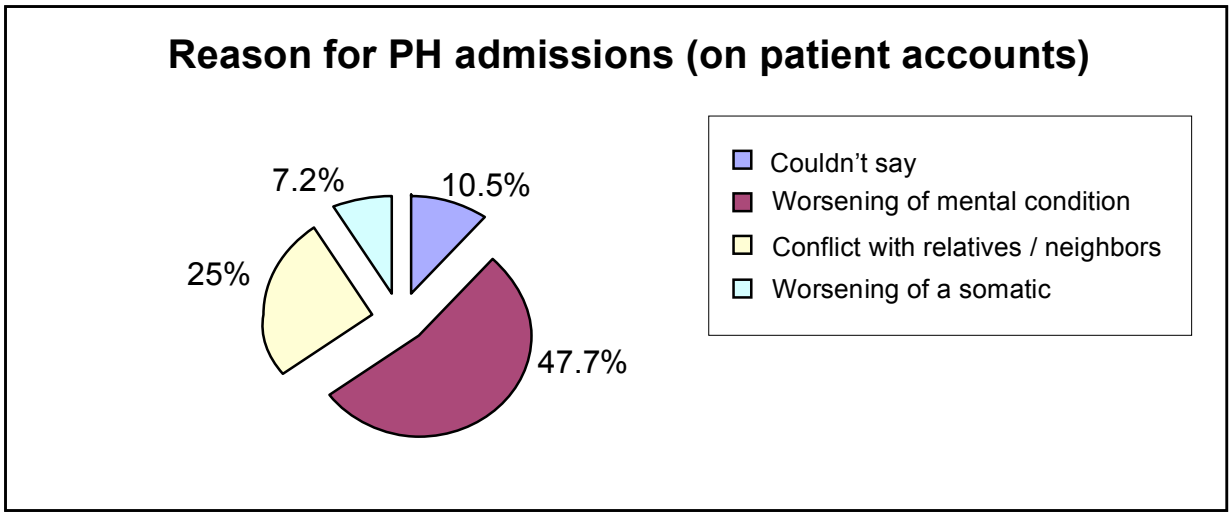


Figure 4.2.3 Reason for admission of PH residents (on patients' accounts)

Cumulative duration of stay in different facilities for the PH residents in the survey ranged between 1 and 201 months, but 15.1% of all respondents could not tell. Yet, Cumulative duration of sickness ranged between 1 and 63 years, averaging 18.19 years. A cross-comparison of the above two indicators revealed that basically one-third of the time a person was living with a mental health problem has been spent within different facilities.

No formal education was reported by a mere 5.3% of respondents, primary education was reported by 6.6%, incomplete secondary education – 14.5%, general secondary – 21.1 %, specialized secondary education – 39.5%, and only 8 respondents, or 5.3%, stated to have higher education, while another 10 had incomplete higher education (6.6%).

A disability degree was reported by 75.7% of PH respondents: 70.4% had a 2nd degree disability, 3.9% had a 1st degree disability, and 1.2% 1.2% - 3rd degree disability (Figure 4.2.4).

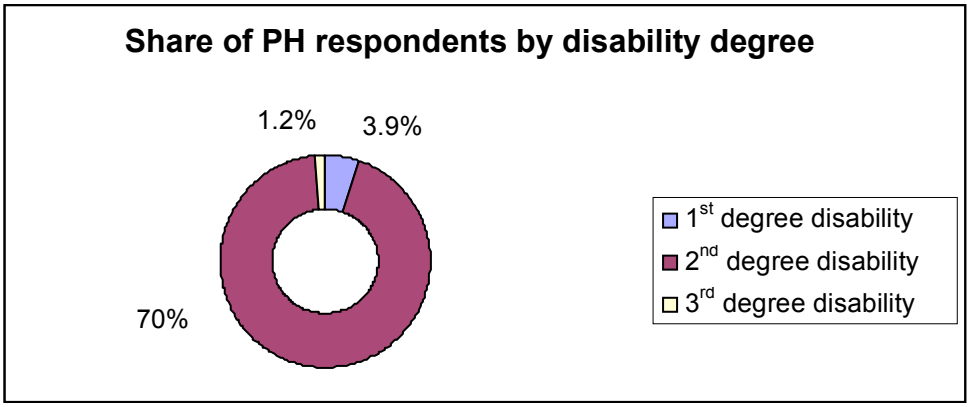


Figure 4.2.4 Distribution of PH respondents by disability degree

However, despite having disability degrees, of the 152 respondents that were interviewed, 133 (87.5%) had no guardian, whereas 16 PH patients, i.e. 10.5%, had a guardian, i.e. were deprived of legal capacity.

As many as 96.7% per cent of them reported to have a family, while the remaining 3.3% stated to have none; 112 respondents (73.7%) reported to have been visiting or visited by their families. Yet, 37 interviewees (24.3%) denied to have had visits to each other with their families. Conversely, 72.4% had a regular contact with their family or relatives versus 26.3% who claimed not to have regular contacts with their families, while 1.3% couldn't say.

Presented below is a review of data collected from the PH residents on section 2 "Health" *(see Annex 1 "Individual Assessment Tool for the Residents of MH Facilities").*

If one is to distribute the above 152 study PH respondents by intellectual disability and mental health problems, one may get the following picture: 43 respondents (28.8%) presented with intellectual disabilities, while another 115 residents (75.7%) people presented with mental health problems (*Figure 5.2.5*). Listed in the *Table 5.2.1* are the incidence and types of intellectual disabilities of PNBH respondents enrolled in the study, as follows.

Table 4.2.1 Distribution of PH respondents by intellectual disability

- Epilepsy	- 37.3%
- Down syndrome	- 6%
- Cerebral palsy	
- Stroke	
- Cerebral trauma	- 7.8%
- Mental retardation	- 31.4%
- Dementia	- 17.6% -

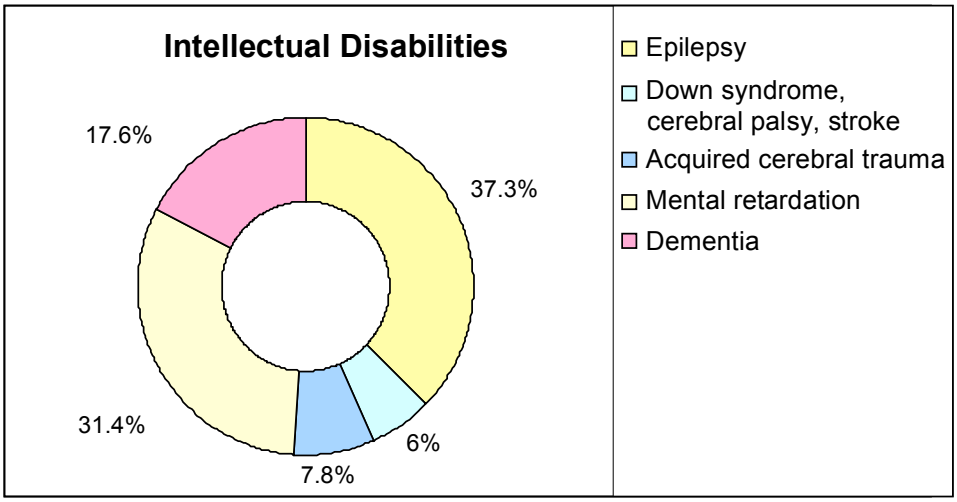


Figure 4.2.5 Distribution of PH respondents by intellectual disability

Listed in the *Table 4.2.2* below are the MH problems of the 115 residents interviewed, as also outlined in *Figure 4.2.6*:

Table 4.2.2 Distribution of PH respondents by MH problem

- Schizophrenia / other psychoses	- 80	- 59.3%
- Anxiety	- 16	- 11.9%
- Bipolar disorders	- 2	- 1.5%
- Personality disorders	- 12	- 8.9%
- Substance abuse / dependence	- 12	- 8.9%
- Depression	- 10	- 7.4%
- Nutrition disorders	- 1	- 0.7%
- Chronic deliria	- 2	- 1.5%

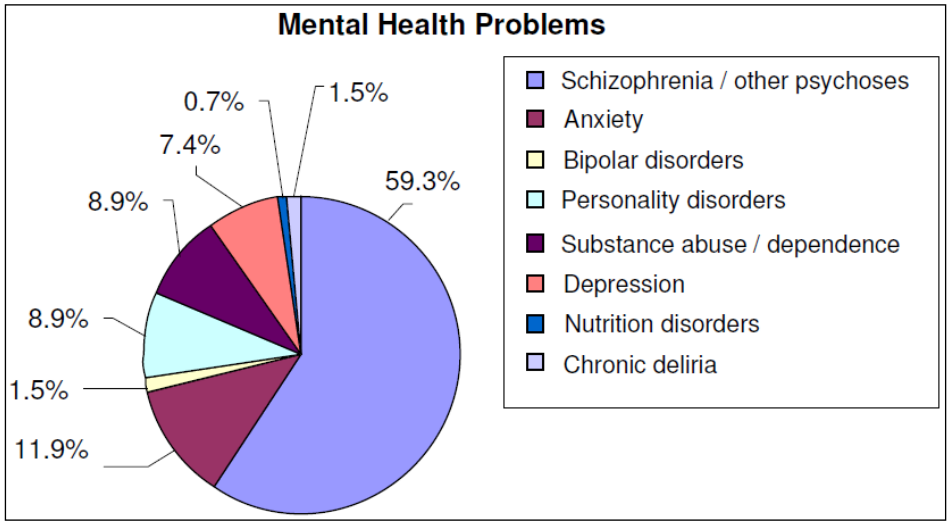


Figure 4.2.6 Distribution of PH respondents by MH problems

Within this study, respondents (152) were also assessed in terms of difficulties they were facing day in, day out, as follows:

a) Difficult behaviors displayed by 62 respondents (40.8%);
b) Difficulty in using verbal language was reported by 10 people (6.6%);
c) Anxiety was reported by 37 people (24.3%);
d) Aggressive conduct was displayed by 52 respondents (34.2%);
e) Locomotor problems were reported by 4 persons (2.6%);
f) Confusion was reported by 4 people (2.6%);
g) Abstinence was reported by 7 persons (4.6%);
h) Disorientation to time, space and person was found in 10 interviewees (6.6%); and
i) Hallucinations and deliria were reported by 75 respondents (49.3%)

Besides mental health problems and intellectual disabilities, some respondents reported also other somatic conditions, complicating furthermore their functions. Listed below are some of those: low/high blood pressure – 17 people (13.7%), hepatitis – 16 people (12.9%), heart conditions – 22 respondents (17.7%), lung conditions – 10 patients (8.1%), gastrointestinal disorders – 14 individuals (11.3%), eye conditions – 8 respondents (6.5%), TB – 3 patients (2.4%), trauma – 4 respondents (3.2%), blood conditions – 2 respondents (1.6%), genitourinary conditions – 5 people (4%), diabetes mellitus – 2 persons (1.6%), and HIV – 2 interviewees (1.6%) (*Figure 4.2.7*).

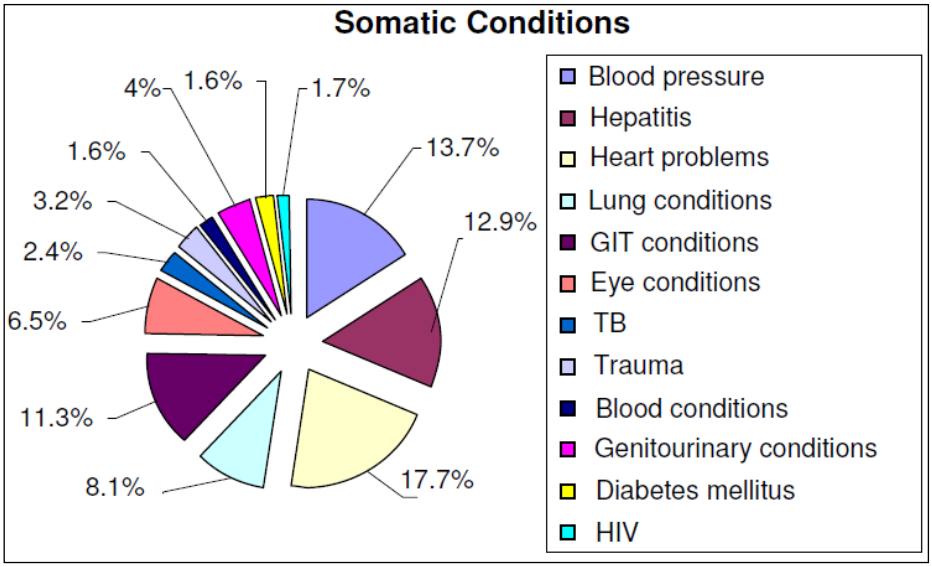


Figure 4.2.7 Distribution of PH respondents by somatic conditions

Support therapy was needed by 110 respondents, or 71.4%; 39 respondents, or 25.7%, required no support medication.

The study revealed locomotor problems in some of those 152 PH respondents. A mere 3.9% of respondents, i.e. 6 persons, required locomotor support, whereas the remaining 96.2% (146) had no locomotor support needs. Almost all respondents (98.7%) had no special diet needs.

The survey of 152 PH respondents outlined that:

- ***15.8% of them were self-sufficient;***
- ***81.6% of them required occasional support (124 respondents);***
- ***2.6% of them of them required regular support (4 respondents);***
- ***There were no fully dependent respondents in this survey (Figure 4.2.8)***

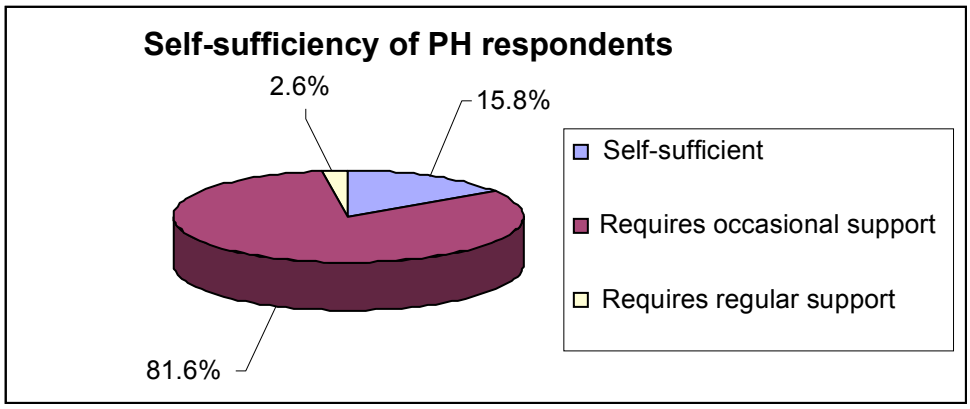


Figure 4.2.8 Self-sufficiency of PH respondents

4.3 Cross-comparison of individual assessments of P.N.B.H. vs. P.H. residents

The data collected separately for PNBH and PH may not be cross-comparable, yet a review of specific indicators may highlight certain conclusions.

The number of admissions is not comparable across PH and PNBH facilities either, as the profile of those facilities differs, which leaves only one relevant indicator – reason for admission.

Reasons for admission differed by type of mental health facility. Most PNBH residents were admitted because they required continuous care (67.5%), followed by referral by the MoLSPF (8.9%), having no relatives to care for them (5.3%) or presenting with certain defects (5.3%) or disability (3.6%).

According to the PH patient charts, the main reason for admission was a worsening in their psychiatric condition (99.3%).

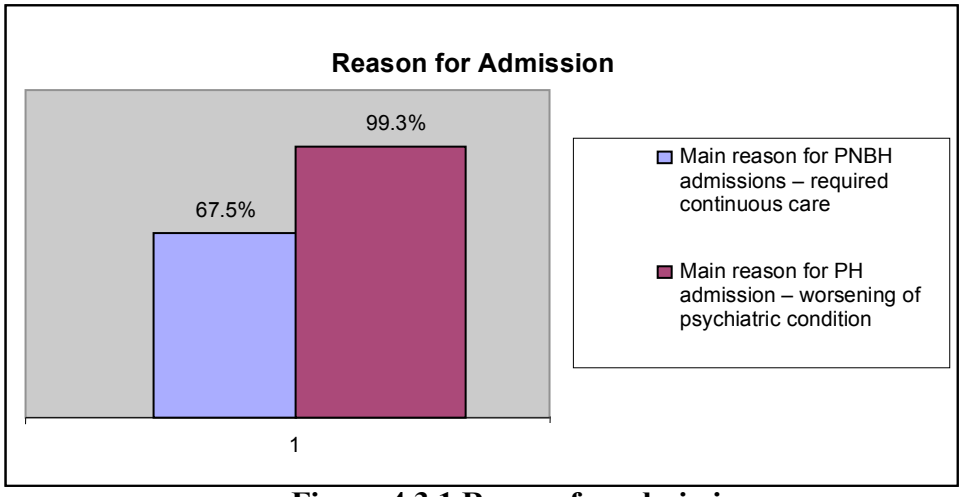


Figure 4.3.1 Reason for admission

Yet, there were respondents from PNBH and PH alike who provided other answers when asked about why they have been admitted to a MH facility. Based on the patient accounts, the reasons for admission differed from the above: 14.2% of PNBH residents claimed to not know the reason of their stay in there, 9.5% claimed that their condition worsened, 7.1% acknowledged to have no relatives to look after them, 4.1% had a conflict with relatives or neighbours, 3.6% confessed to have been brought in by a relative, and families could not care for another 3.6% of them. A review of data collected from the PH residents showed the following: 47.4% of PH residents were hospitalized due to their psychiatric condition worsening, 25% had a conflict with relatives or neighbours; while a somatic condition worsened in another 7.2% of them etc. Hence, the data collected from medical records do not match the answers provided by residents, thus signalling a mere formal recording of one's reason for admission in a facility's registry.

In terms of guardianship, 63 respondents had a guardian in PNBH vs. 16 people in PH, accounting for 24.6% of all respondents for both types of facilities.

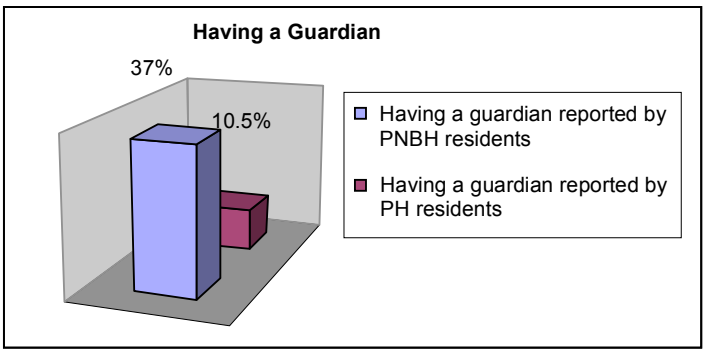


Figure 4.3.2 Guardianship

Of the 321 residents that were interviewed, 71 in PNBH and 147 in PH had families. As many as 41 PNBH and 112 PH respondents stated to have been visiting and visited by their families, accounting for 47.7% of the total number of respondents.

Of the 169 PNBH respondents interviewed, 121 (71.6%) presented with intellectual disability versus 56 people (33.1%) presenting with mental health problems. Of the 152 PH respondents interviewed, 43 (28.8%) presented with intellectual disability versus 115 respondents (75.7%) presenting with mental health problems. *This cross-comparison reveals explicitly the kind of services provided by each type of facility: services targeting mental health problems in PH versus social care services in PNBH.*

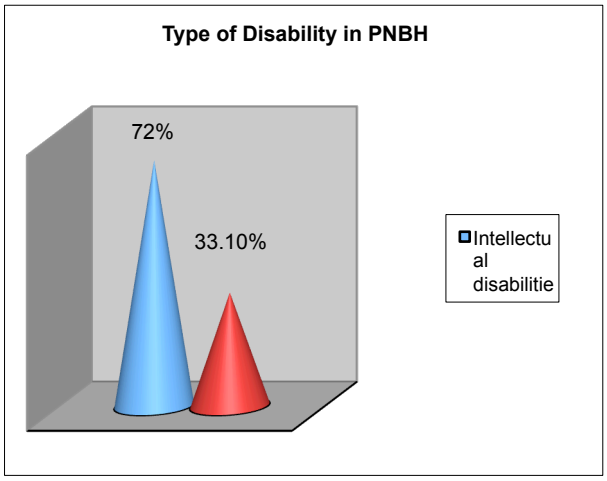


Figure 4.3.3 Type of disability in PNBH

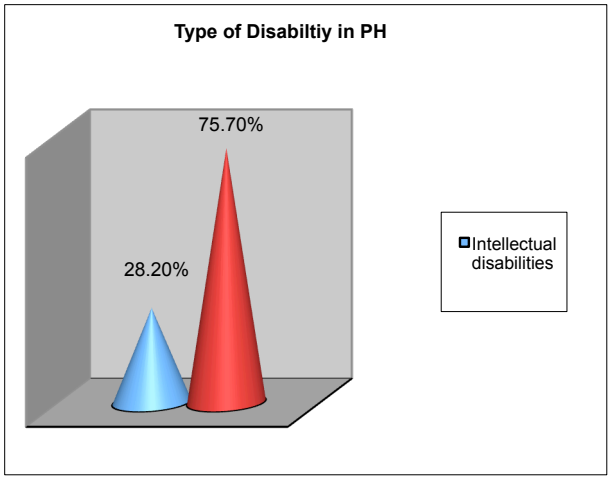


Figure 4.3.4 Type of disability in PH

Listed below are the intellectual disabilities reported in PH: epilepsy – 19 people (37.3%), mental retardation – 16 respondents (31.4%), dementia – 9 people (17.6%), acquired cerebral trauma – 4 individuals (7.8%), while the remaining 6% are equally distributed between the Down syndrome, cerebral palsy, and stroke. As for the 121 PNBH respondents the

distribution of disability was as follows: epilepsy – 14 people (9.6%), Down syndrome – 5 individuals (3.4%), cerebral palsy – 15 respondents (10.3%), acquired cerebral trauma – 4 people (2.7%), mental retardation – 104 respondents (71.2%), and dementia – 4 individuals (2.7%).

Listed below are the mental health conditions of the 56 PNBH residents:

Table 4.3.1 Distribution of PNBH respondents by intellectual disability

- Schizophrenia / other psychoses	- 85.7%
- Bipolar disorders	- 12.5%
- Personality disorders	- 1.8%

Listed below are the mental health conditions of the 115 PH residents:

Table 4.3.2 Distribution of PH respondents by intellectual disability

- Schizophrenia / other psychoses	- 59.3%
- Anxiety	- 11.9%
- Bipolar disorders	- 1.5%
- Personality disorders	- 8,9%
- Substance abuse / dependence	- 8.9%
- Depression	- 7.4%
- Nutrition disorders	- 0.7%
- Chronic deliria	- 1.5%

In terms of the challenges / barriers faced by respondents on a daily basis, the following conclusions could be drawn: difficult and aggressive behaviours, anxiety, abstinence, hallucinations and deliria, disorientation to time, space or person – were all reported more often by PH patients. Conversely, the following key barriers were reported by PNBH respondents: difficulty in using verbal language, locomotor problems and confusion, which were, in fact, characteristic for the disabled in general.

Besides mental health problems and disabilities, PH and PNBH residents alike reported also some general medical conditions. Those somatic conditions differed little across the two types of MH facilities, as follows:

- Blood pressure related problems – 14–21%;
- Hepatitis – circa 13%;
- Heart conditions – 13–18%

As many as 46.2% of PNBH respondents required support medication versus 72.4% of PH respondents, which was in line with the idea that PH residents suffered mostly from psychiatric disorders.

Looking into one's degree of self-sufficiency (autonomy) in *Table 4.3.3* below in both PNBH and PH, one may conclude that there were very few fully dependent residents in general, and only within PNBH. Nevertheless, there were absolutely self-sufficient residents in both types of facilities – 5% in PNBH and 16% in PH. Given the above, one may claim that some proportion of the PNBH residents could be deinstitutionalized without any additional support. Moreover, most respondents in either facility required occasional support only, with more of them in PH.

Table 4.3.3 Self-sufficiency of PNBH and PH residents

	PNBH	**PH**
Self-sufficient	4.7%	15.8%
Occasional support	58%	81.6%
Regular support	37.3%	2.6%
Fully dependent	1.2%	-

4.4 INSTITUTIONAL ASSESSMENT OF P.N.B.H. FACILITIES

The institutional assessment tool consists of a general section and a section with specific indicators, based on a "traffic light" assessment methodology. The general section data revealed the following: PNBH were located in 4 distinct administrative sites, as follows:

- PNBH in the village of Badiceni, district of Soroca
- PNBH in the municipality of Balti
- PNBH in the village of Branzeni, district of Edinet
- PNBH in the village of Cocieri, district of Dubasari

Three of the four PNBH were located in rural areas, and only PNBH Balti was located in a sub-urban area. All facilities were multi-storey buildings, the maintenance of which has been eating up the lion's share of the budget.

PNBH Branzeni may be accessed by public transportation, whereas one may encounter problems getting to PNBH Balti or PNBH Cocieri by public transportation, i.e. few travels a day only. PNBH Badiceni may not be accessed by public transportation at all, as the transportation goes to the village only, thus visits by the relatives / families or to families is limited.

All four PNBH are social care facilities, providing residential care services to mixed groups of residents (male and female) with mental health conditions and psycho-neurological disorders 18 years of age and older.

Each of the four facilities from above started to operate as of a different date, namely:

- PNBH Badiceni has been providing residential care since 1950;
- PNBH Balti has been providing residential care since 1981;
- PNBH Branzeni has been providing residential care since 1980; and
- PNBH Cocieri has been providing residential care since 1976.

Yet, each PNBH has been providing more or less the same number of services, namely:

1) Healthcare;
2) Nutrition;
3) Medication;
4) Accommodation services;
5) Medical check-up and consultations;
6) Pharmaceutical services;
7) Occupational therapy / ergotherapy.

The only difference was the availability of occupational therapy / ergotherapy, which was missing in the PNBH Balti. Church was the only outstanding place they were going to.

There is one sewing workroom at the PNBH Badiceni, equipped with 3 sewing units, making it possible to engage only up to 15 residents. Moreover, there was a mini-library, which was barely used by residents. There used to be one furniture mounting workshop, which is no longer operating. Those workshops were created with the framework of a foreign investment project, which were no longer operating once the project was over.

PNBH Branzeni had a quite diverse range of OT activities. That facility had a number of projects to diversify the spare time of residents by getting them involved in activities, such as:

- Room with PCs and Internet access (Wi-Fi all throughout the facility);
- Knitting (produced 7,000 pieces of handicrafts);
- Two greenhouses;
- Orchard (4 hectares);
- Small cattle and pig farm;
- Carpentry workroom;

- Sewing workroom (for the refurbishing of their own clothing)

The above activities were quite diverse in nature, but were not systematic and it was quite difficult to be used as alternative employment.

Likewise, PNBH Cocieri residents may also be engaged in greenhouse or orchard activities. Products grown in the greenhouse are used to diversify the menu of residents. There is also a kitchen to be used as a workroom, but no signs of any activity were noticed.

The average length of stay for residents is not computed in any of PNBH. These data could be retrieved from the medical records of each patient and were known for each respondent individually. Nevertheless, the MoLSPF set forth in its Social Report 2012 that the average length of stay for PNBH respondents was 9 years.

PNBH is a place for temporary stay and the family may take a resident home at any time. Yet, despite having this opportunity, the number of discharges was quite small. Residents may not be discharged at their own request, as someone from the community has to file such an application, thus securing accommodation for those. The number of respondents discharged over the last 12 months varied across facilities, as follows:

- ✓ PNBH Badiceni – 2 people discharged;
- ✓ PNBH Balti – 2 people discharged;
- ✓ PNBH Branzeni – 2 people discharged;
- ✓ PNBH Cocieri – 3 people discharged.

The number of residents transferred to other facilities also differed, as follows:

- ✓ PNBH Badiceni – 1 resident transferred out;
- ✓ PNBH Balti – no resident was transferred out;
- ✓ PNBH Branzeni – 1 resident transferred out;
- ✓ PNBH Cocieri – 18 residents transferred out

The total number of beds and the number of residents getting temporary support over the last year differed across PNBH:

- PNBH Badiceni – 460 beds, providing temporary support to 439 residents;
- PNBH Balti – 550 beds, providing temporary support to 535 residents;
- PNBH Branzeni – 300 beds, providing temporary support to 307 residents;
- PNBH Cocieri – 355 beds, providing temporary support to 364 residents.

Each of the above PNBH facilities benefited from a range of minimum common services ensuring decent living conditions, such as water supply and sewerage, power, natural gas etc. all

facilities have been benefiting from a list of basic utilities, whereas there were also additional services ascertained in some other facilities, as follows:

PNBH Badiceni:

- Water supply from the artesian well;
- Sewerage;
- Power supply.

PNBH Balti:

- Sewer
- Power supply
- Natural gas supply
- Diesel generator
- Library
- Church
- Large room for events / celebrations

PNBH Branzeni:

- Sewer
- Power supply
- Departmental water supply

PNBH Cocieri:

- Library
- Large room for events / celebrations

Regarding the section of the institutional assessment tool with more specific indicators, one could notice the following:

Subsection ***Consent***, i.e. resident's consent to temporary placement and treatment, was assessed in all 4 PNBH and got a RED score, as none of the respondents has signed an institutionalization agreement, most being put there by referral from the MoLSPF. It is the MoLSPF that creates a file with the request of placement and signed by the person.

Subsection ***Family Involvement*** got an AMBER score in all PNBH except the one in Cocieri, which scored RED. In this latter PNBH less than 10% of respondents reported to have been visiting or visited by family members, i.e. one-in-ten of respondents do keep in touch with their family by different means, including by visits.

Subsection on the ***Sharing of Information*** in all PNBH facilities got an AMBER score, as a considerable share of respondents has been getting from the PNBH staff the information about the treatment they were getting. There were posters on the walls with information about certain diseases, such as HIV and hepatitis.

Subsection ***Nutrition*** for PNBH in Badiceni and PNBH Branzeni scored GREEN, as the actual menu fully matched the stated menu (on the plates of respondents), as corroborated both by observation and residents' accounts. Nutrition was rich in cereals, fresh seasonal vegetables and fruits, meat and fish, and dairy products. PNBH Balti and PNBH Cocieri scored AMBER, even if the actual menu matched the stated menu, because the food was less rich in all necessary ingredients.

It was difficult to assess the section ***Other Basic Needs***; therefore, a more detailed assessment was performed by specific items:

0. *Lockers / bedside stands for personal belongings* – all PNBH scored AMBER, as those were available in half of all facilities;
1. *Washers* for use in groups or mini-groups – only PNBH Badiceni scored AMBER, while the other three scored RED;
2. *Intimacy* (as reflected by the number of residents in a group) – PNBH Badiceni and PNBH Branzeni had very few rooms, accommodating 2–3 persons each, thus getting a RED score, whereas PNBH in Balti and PNBH Cocieri had more rooms, scoring AMBER;
3. *Shower / WC* (enough available, one may use those as many times as needed, are separated and clean) – except for PNBH Cocieri, which scored RED, the remaining facilities got an AMBER score, meeting two of the three criteria from above.

Subsection ***Wellbeing*** scored AMBER in all facilities.

Scores for the section ***Operations*** varied across facilities, subject to occupational therapy / ergotherapy opportunities available to respondents:

- PNBH Badiceni scored AMBER;
- PNBH Balti scored RED;
- PNBH Branzeni scored GREEN;
- PNBH Cocieri scored AMBER.

Mental and Health Needs of all PNBH mostly got an AMBER score, except for PNBH Branzeni that scored GREEN on mental needs, as mental health specialists were very reachable and open to residents.

Choice of Services available to residents, which includes, among other, choice of roommates, got a GREEN score for PNBH Balti and PNBH Cocieri, and RED score for PNBH Badiceni and PNBH Branzeni.

Freedom was another criterion for institutional assessment. It meant that residents were free and encouraged to communicate with relatives and friends. Therefore, service users of PNBH were free and encouraged to get in touch with friends and local community. Public telephone booths were available and accessible. ***Freedom*** for all PNBH was assessed as AMBER, except for PNBH Balti that got a GREEN score. ***Condition of Buildings*** scored AMBER for PNBH Badiceni and Cocieri, GREEN for PNBH Balti, and RED for PNBH Branzeni. Three of the four PNBH scored GREEN on **Hygiene**, except PNBH Balti that got AMBER.

Management of Difficult Behavior scored differed across facilities, based on the presence of locked wards and constraint measures used there: PNBH Badiceni – AMBER, PNBH Balti – RED, with 2.5 isolations weekly, PNBH Branzeni – GREEN, PNBH Cocieri – RED.

Staffing in three of the four PNBH facilities was assessed as AMBER, except for PNBH Cocieri - GREEN. Contrary, availability of mental health specialists scored GREEN only for PNBH Branzeni, while the other scored AMBER.

Total staff-to-residents ratio differed by facility:

- PNBH Badiceni – 209 staff, including 5 psychiatrists and 3.5 other mental health professionals vs. 460 residents: 2.2 residents per staff;
- PNBH Balti – 209 staff, including 7 psychiatrists and 7 other mental health professionals vs. 550 residents: 2.63 residents per staff;
- PNBH Branzeni – 143 staff, including 7 psychiatrists and 7 other mental health professionals vs. 300 residents: 2.1 residents per staff;
- PNBH Cocieri – 160 staff, including 7 psychiatrists and 3 – other mental health professionals vs. 335 residents: 2.1 residents per staff.

Skilled healthcare was available 24/7 in all PNBH facilities.

- PNBH Badiceni had 205 full-time staff and 2 part-time staff.
- PNBH Balti had 232 full-time staff and 1 part-time staff.
- PNBH Branzeni had 143 full-time staff.

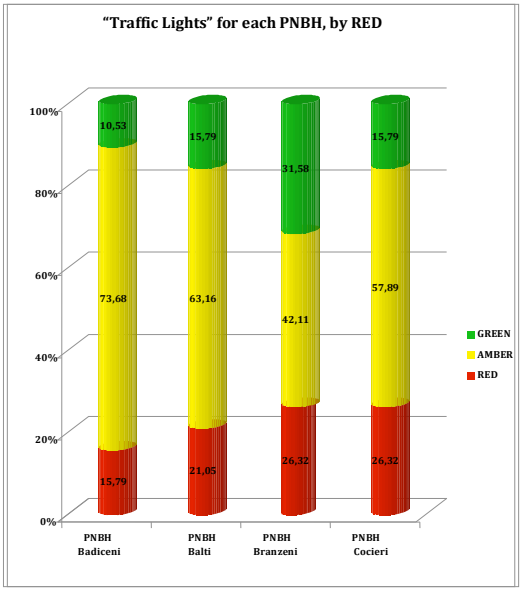
- PNBH Cocieri had 154 full-time staff and 7 part-time staff.

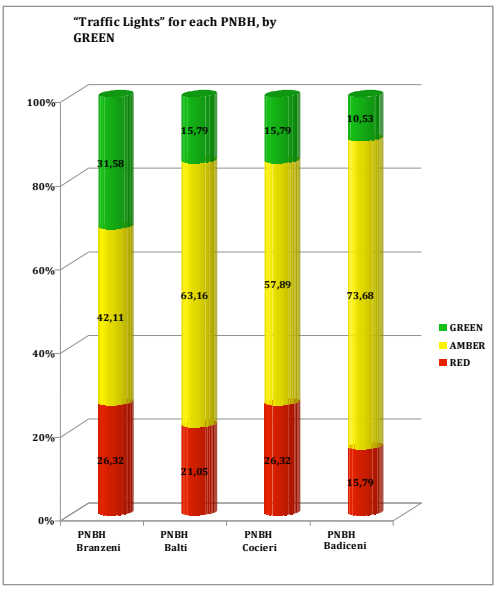
There was need for nursing and aiding staff in PNBH Badiceni and PNBH Branzeni.

The table below shows the share of "traffic light" scores by each facility:

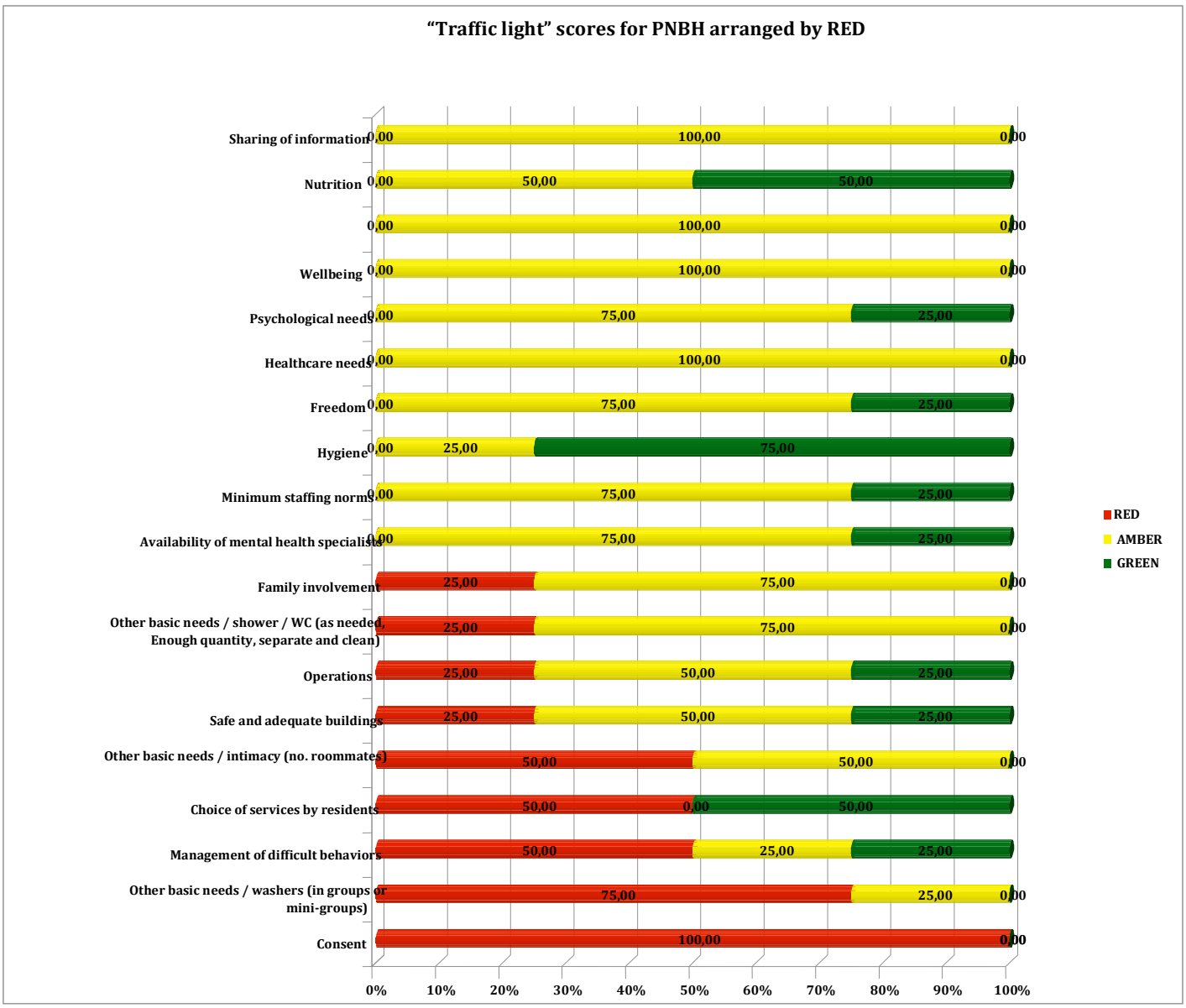
		RED	AMBER	GREEN	%
1	PNBH Badiceni	15.79	73.68	10.53	100.00
2	PNBH Balti	21.05	63.16	15.79	100.00
3	PNBH Branzeni	26.32	42.11	31.58	100.00
4	PNBH Cocieri	26.32	57.89	15.79	100.00

Two charts were plotted based on the table data below, outlining the share of traffic light scores for each PNBH by RED and GREEN. Hence, one may notice that the poorest situation was reported in PNBH Cocieri and PNBH Branzeni, with RED scores accounting for 26.32% of all, while the highest share of GREEN was also reported in PNBH Branzeni, tallying up to 31.58%.

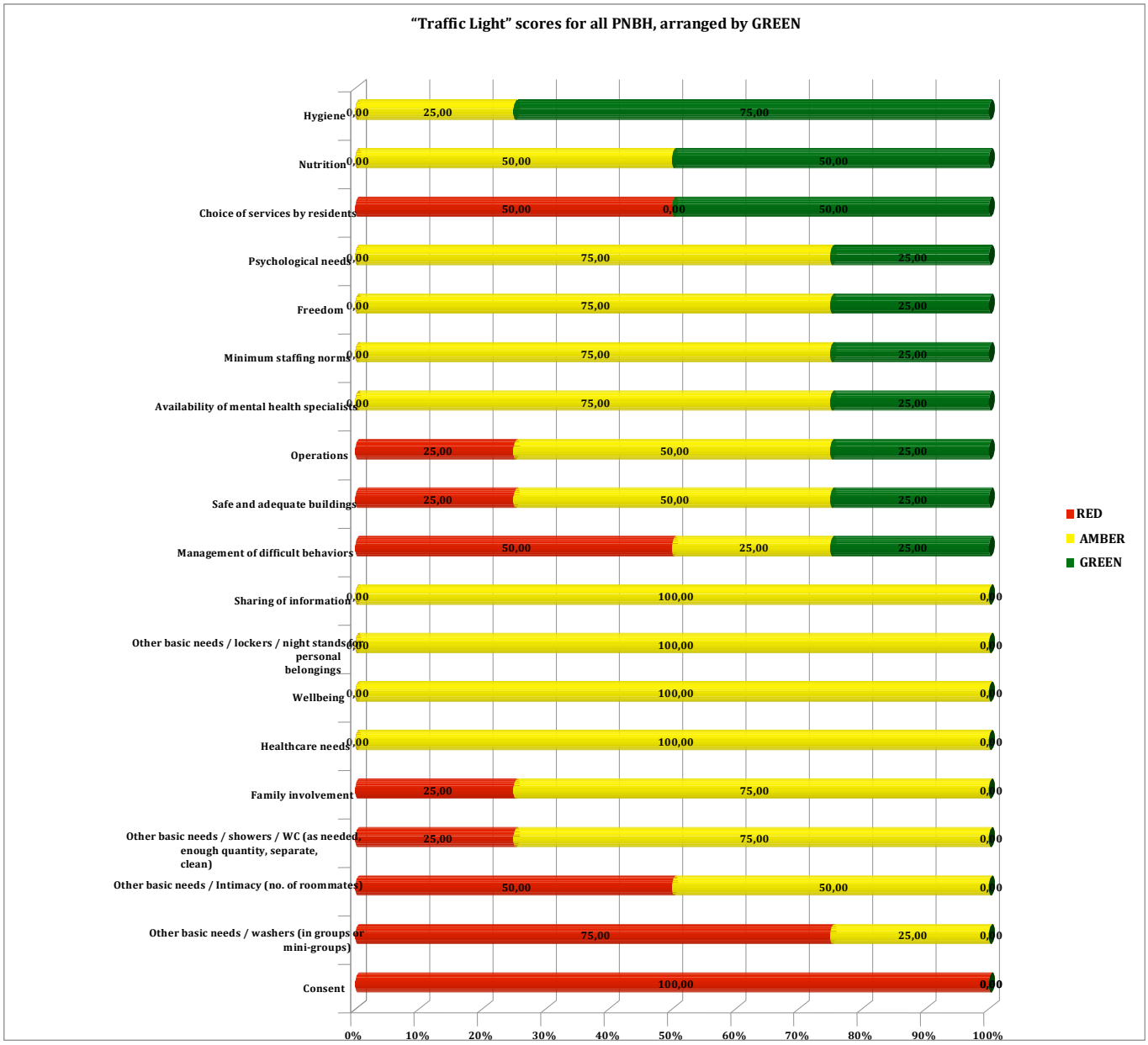




The chart below shows the ranking of specific indicators by traffic light scores arranged by RED. One may see that ***consent*** is the lowest ranked indicator as it scored 100% RED, requiring improvement, whereas indicators such as ***other needs*** and ***management of difficult behaviors*** were poor respectively in 75% and 50% of PNBH facilities.



The histogram below lays out specific "traffic light" indicators arranged by GREEN. Thus, one may see that the best indicator, yet scoring only 75%, was ***hygiene***, whereas ***nutrition*** and ***opportunity to chose services*** reported by 50% on average in all PNBH.


"Traffic Light" scores for all PNBH, arranged by GREEN
Hygiene
0,00
25,00
75,00
Nutrition
0,00
50,00
50,00
Choice of services by residents
50,00
0,00
50,00
Psychological needs
0,00
75,00
25,00
Freedom
0,00
75,00
25,00
Minimum staffing norms
0,00
75,00
25,00
Availability of mental health specialists
0,00
75,00
25,00
Operations
25,00
50,00
25,00
Safe and adequate buildings
25,00
50,00
25,00
Management of difficult behaviors
50,00
25,00
25,00
Sharing of information
0,00
100,00
0,00
Other basic needs / lockers / night stands (for personal belongings
0,00
100,00
0,00
Wellbeing
0,00
100,00
0,00
Healthcare needs
0,00
100,00
0,00
Family involvement
25,00
75,00
0,00
Other basic needs / showers / WC (as needed, enough quantity, separate, clean)
25,00
75,00
0,00
Other basic needs / Intimacy (no. of roommates)
50,00
50,00
0,00
Other basic needs / washers (in groups or mini-groups)
75,00
25,00
0,00
Consent
100,00
0,00
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
RED
AMBER
GREEN

4.5 Institutional assessment of psychiatric hospitals

The institutional assessment tool consists of a general part and a section with specific indicators, based on a "traffic light" assessment methodology. The general section data revealed the following: psychiatric hospitals (PH) were located in 3 administrative sites, as follows:

- PH Balti, municipality of Balti
- CPH Costiujeni, municipality of Chisinau
- PH Orhei, district of Orhei

All three PH were located in suburban areas. All facilities were huge multi-storey buildings. PH Balti and CPH Costiujeni were reachable by public transportation, whereas access to public transportation was difficult for PH Orhei.

All three PH are healthcare facilities of hospital type, providing residential care services to mixed groups of residents (male and female) with mental health conditions 3 years of age and older for Balti and Costiujeni or 18 years of age and older for PH Orhei.

Each of the three facilities from above started to operate as of a different date, namely:

- PH Balti – since 1978
- CPH Costiujeni – since 1895
- PH Orhei – since 1959

Each PH has been providing more or less the same number of services, but it is worth listing those separately:

PH Balti:

1. Healthcare
2. Nutrition
3. Medication
4. Accommodation
5. Functional diagnostics
6. Speech therapy
7. School education
8. Morbid anatomy
9. Laboratory
10. Consultative-medic services
11. Pharmaceutical services
12. Occupational therapy / ergotherapy

CPH Costiujeni:

1. Healthcare
2. Nutrition
3. Medication
4. Accommodation
5. Functional diagnostics
6. Speech therapy
7. School education
8. Morbid anatomy
9. Laboratory
10. Consultative-medical services
11. Pharmaceutical services
12. Occupational therapy / ergotherapy

PH Orhei:

1. Healthcare
2. Nutrition
3. Medication
4. Accommodation
5. Functional diagnostics
6. Laboratory
7. Consultative-medical services
8. Pharmaceutical services

Each ward at the PH Balti had an occupational therapy room, which was not used to its capacity. Those occupational therapy rooms were created with foreign investments, which were no longer operating once the project ended. CPH had a sewing workroom, with no residents noticed around, while there were no OT services at all at PH Orhei.

The average duration of admission of residents was as follows:

1. PH Balti – 32 days;
2. CPH – 33.67 days;
3. PH Orhei – 33.8 days

Listed below is the number of residents discharged home over the last 12 months, which varied across facilities and which basically is indicative of the number of discharges over 2012:

- ✓ PH Balti – 9,276 people discharged;
- ✓ CPH – 9,235 people discharged;
- ✓ PH Orhei – 2,169 people discharged

The number of residents transferred out to other facilities also varied across facilities:

- ✓ PH Balti – 41 residents transferred out;
- ✓ CPH – 13 residents transferred out;
- ✓ PH Orhei – 9 residents transferred out

The total number of beds and the number of residents getting temporary support over the last year differed across the hospitals:

- PH Balti – 770 beds, providing temporary support to 7,500 residents last year;
- CPH – 960 beds, providing temporary support to 9,148 residents last year;
- PH Orhei – 200 beds, providing temporary support to 2,180 residents last year.

Regarding the section of the tool with specific indicators, one could notice the following:

Subsection ***Consent***, i.e. resident's consent to temporary placement and treatment, was assessed in all 3 PH as GREEN. Subsection ***Family Involvement*** scored AMBER in all PH.

Subsection ***Sharing of Information*** in CPH and PH Orhei got an AMBER score, as the information was provided verbally only and there was none available in writing, or GREEN score at PH Balti, as there were posters put on the walls all over the hospital with different information for the patients.

Subsection ***Nutrition*** for PH Balti and CPH Costiujeni scored AMBER and PH Orhei got a RED score, as the latter had significant debts, thus not being able to meet their residents' nutritional needs.

It was difficult to assess the chapter ***Other Basic Needs***; therefore, a more detailed assessment was performed by specific items:

4. *Lockers / bedside stands for personal belongings* – PH Balti and CPH scored AMBER, while PH Orhei got a RED score;
5. *Washers* for use in groups or mini-groups – all 3 facilities scored RED;
6. *Intimacy* (as reflected by the number of residents in a group) – PH Balti and CPH scored AMBER, while PH Orhei got a RED score;
7. *Shower / WC* (available in sufficient numbers, one may use those as many times as needed, separated and clean) – PH Balti scored AMBER, while CPH and PH Orhei scored RED.

Subsection ***Wellbeing*** scored AMBER in all facilities.

Scores for the section ***Operations*** varied across facilities, subject to occupational therapy / ergotherapy opportunities available to respondents:

- PH Balti scored AMBER;

- CPH and PH Orhei scored RED.

Mental Needs got a RED score, while ***health needs*** in all PH facilities were assess as AMBER. ***Choice of Services*** available to residents, which includes, among other, choice of roommates, got a RED score for all hospitals.

Freedom for PH Balti and CPH was assessed as AMBER (the wards were locked up, but patients were allowed to have a phone, could be visited by family and some could even get out of the ward for a walk), whereas PH Orhei got a RED score (people there were not allowed to get out of the ward). ***Condition of Buildings*** at Balti and Costiujeni scored AMBER, and at Orhei scored RED. All PH facilities scored AMBER on hygiene.

Management of Difficult Behavior scored AMBER for all PH, averaging about 43 isolations each year. Skilled healthcare was available 24/7 in all PH facilities.

Staffing was assessed as AMBER, and so did the availability of mental health specialists.

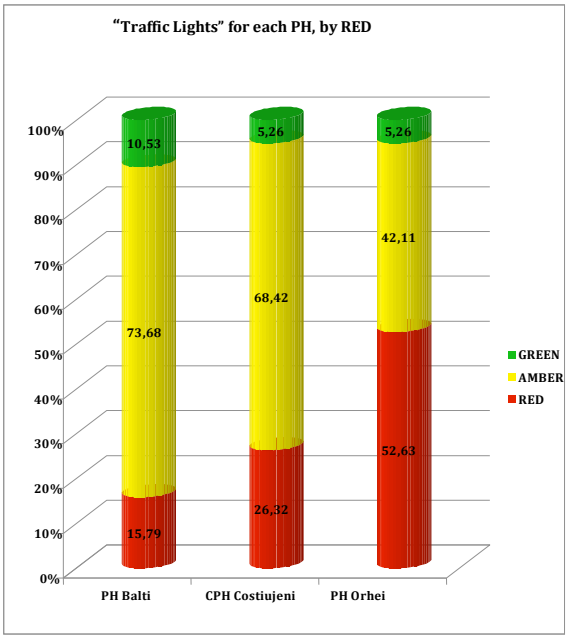
Total staff-to-residents ratio differed by facility:

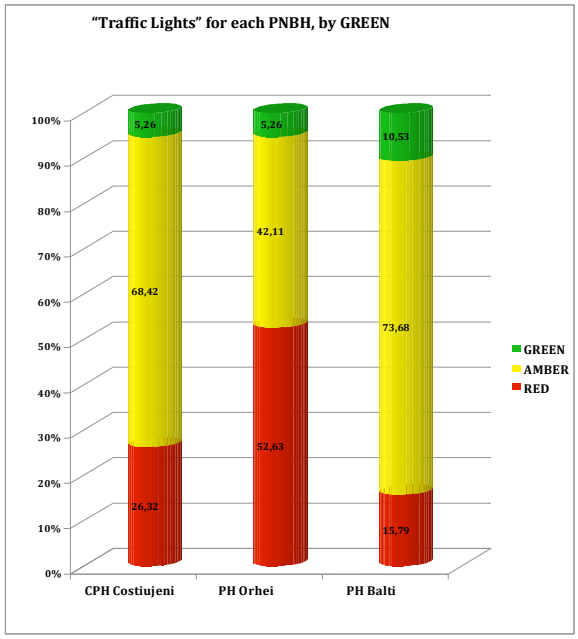
- PH Balti – 893.25 staff, including 24.25 psychiatrists (individuals) and 3 – other mental health professionals, attending to 830.75 residents: 0.93 residents per staff;
- CPH Costiujeni – 1,025.5 staff, including 90.5 psychiatrists (individuals) and 3 – other mental health professionals, attending to 942 residents: 0.92 residents per staff;
- PH Orhei – 214 staff, including 7 psychiatrists and 3 – other mental health professionals, attending to 187 residents: 0.87 residents per staff.

The table below shows the share of "traffic light" scores by each facility:

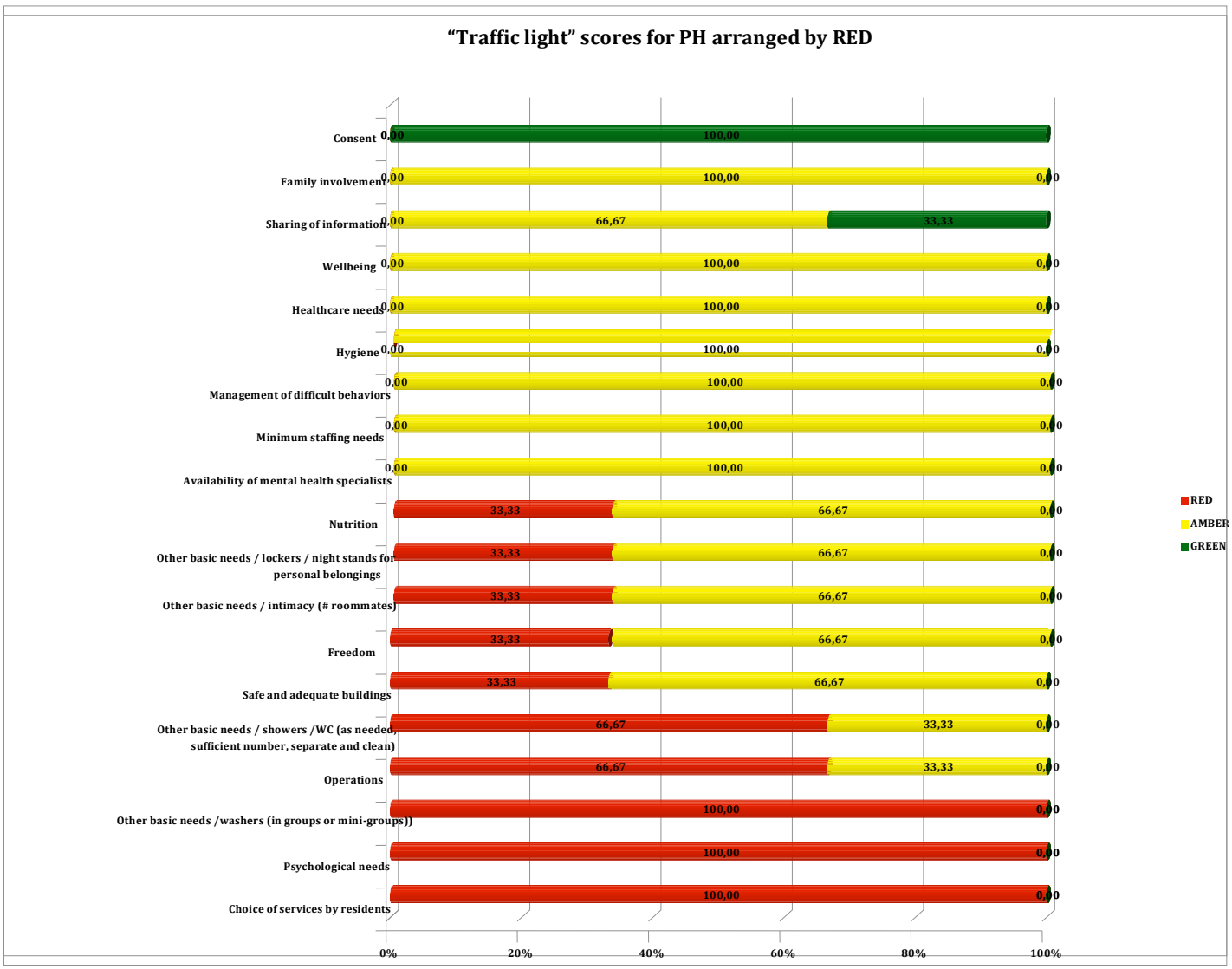
		RED	AMBER	GREEN	%
1	PH Balti	15.79	73.68	10.53	100.00
2	CPH, Costiujeni	26.32	68.42	5.26	100.00
3	PH Orhei	52.63	42.11	5.26	100.00

Two charts were plotted based on the table data below, outlining the share of traffic light scores for each PH by RED and GREEN. Hence, one may notice that the poorest situation was reported in PH Orhei, with RED scores accounting for 52.63% of all, followed by CPH with 26.32% and PH Balti with 15.79%, while the highest share of GREEN was reported in PH Balti with 10.53%, which was quite low.

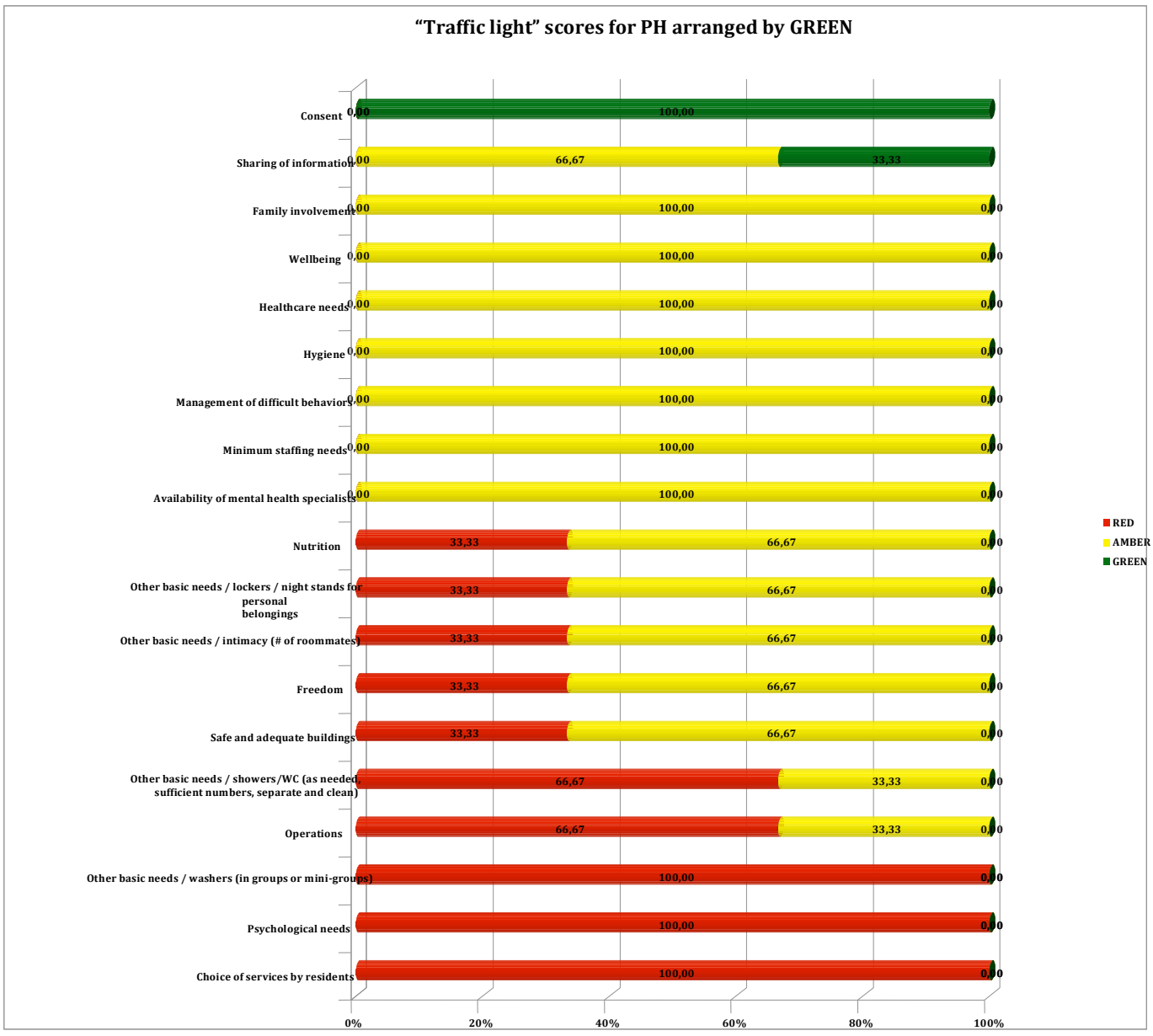




The chart below shows the ranking of specific indicators by traffic light scores arranged by RED. One may see that indicators such as ***choice of activities by residents***, ***psychological needs*** and ***other basic needs (washers)*** had the lowest scores, namely 100% RED, requiring considerable improvement. Such indicators as ***other basic needs (showers/WC)*** and ***activities*** had a poor score in 67% of all PH facilities, also requiring improvement.



The histogram below lays out specific "traffic light" indicators arranged by GREEN. Thus, one may see that only two indicators scored GREEN, namely, ***consent 100%*** and ***sharing of information*** scoring only 33%.


"Traffic light" scores for PH arranged by GREEN
Consent
Sharing of information
Family involvement
Wellbeing
Healthcare needs
Hygiene
Management of difficult behaviors
Minimum staffing needs
Availability of mental health specialists
Nutrition
Other basic needs / lockers / night stands for personal belongings
Other basic needs / intimacy (# of roommates)
Freedom
Safe and adequate buildings
Other basic needs / showers/WC (as needed, sufficient numbers, separate and clean)
Operations
Other basic needs / washers (in groups or mini-groups)
Psychological needs
Choice of services by residents
0,00
100,00
66,67
33,33
33,33
66,67
66,67
0%
20%
40%
60%
80%
100%
RED
AMBER
GREEN

CHAPTER V - DISCUSSION

Regarding Moldova after the independence (1989) we can find different effort in mental health field. During 25 years after, Moldova past very difficult period of civil and economic transition. The worsening of mental health indicators was determined by more factors: the insufficient number of specialist in the psychiatric sphere, including children psychiatry, the decrease of the number of beds meant for inpatient treatment, the small number of alternative mental health services as compared to traditional services provided in hospitals, etc. Within the period of 2005-2009, in the Republic of Moldova, certain actions were undertaken for the development of mental health system by adopting the Mental Health Declaration for Europe (05.01.2005), National Program on Mental Health for years 2007-2011 (30.03.2009), adopting the amendments of the Law regarding Mental Health (28.02.2008)[14]. These were the observations of feasibility study regarding the development of the mental health services in the Republic of Moldova, provided by "SocioPolis" with financial support by SDC in Moldova – the first study provided in our country. Despite of different time that the both studies were provided, the main tendencies were the same: prevention of deinstitutionalization of people with mental disorders, provision of mental health services on community level based on user's satisfaction and good coordination of mental health reform.

An other important document for Republic of Moldova and for reforming mental health system was UN Convention Convention on the Rights of Persons with Disabilities, that put on the national agenda the importance of deinstitutionalization's process of people with mental illness. It was ratified in Moldova in 2010 and the present study was commissioned by the Ministry of Labor, Social Protection and Family and the by the Ministry of Health, with the World Health Organization support, to provide for effective enforcement of article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD) and to get a snapshot of current status of the mental health facilities in the Republic of Moldova.

The present study is very innovative in Moldova. So far no one in the country has asked the question about beneficiaries' autonomy in mental health residential institutions. A review of national literature showed that no research has been promoted in Moldova in this field. The *purpose* of this study was to assess the individual needs of beneficiaries and their level of self-sufficiency within residential care for the planning of mental health system reforms and

[14] Feasibility study regarding the development of the mental health services in the Republic of Moldova

http://www.somato.md/index.php?option=com_docman&task=cat_view&gid=18&dir=DESC&order=name&Itemid=53&limit=20&limitstart=20

deinstitutionalization in the Republic of Moldova. In order to achieve the research 'results we used two global tools: a questionnaire for individual assessment of mental health facility residents, and an institutional assessment questionnaire. These two questionnaires were adapted from a s*tudy conducted by the Mental Health Foundation (UK) and Trimbos Institute (Netherlands), in collaboration with WHO/Europe and national experts from Turkey, for the Ministry of Health and the Ministry of Family and Social Policy of Turkey*[15]. The *individual assessment questionnaire* was an assessment performed by the person that is getting the care or support from the facility. We evaluated 10% of the beneficiaries from all mental health institutions, because, in our opinion, this was the minimum sampling that was able to give us the possibility to have some imagination about real situation.

This assessment was focused on the services provided by the psychiatric hospitals of the MoH and residential care facilities (psycho-neurological boarding houses) for people with mental disability of the MoLSPF. Those have been assessed separately, with subsequent integration of data for cross-comparison.

A very important role and challenge for Moldova had the Stability Pact Project in Mental Health provided by South-Eastern European Health Network[16] and the continue influence on local Government. The recent "Mental Health Situation Analysis in the South-eastern Europe Health Network Member States[17]" provided by Regional Health Development Center on Mental Health had aim to assess current state of mental health activities across SEE Network Member States in order to develop Project Proposal for future activities of the RHDC on Mental Health which will respond to specific needs of the SEEHN Member States. The conclusions were about the mental health policies and legislation, monitoring, evaluation and quality assurance, mental health financing and services, community mental health centres, workforce in mental health and service users.

These two studies are not comparable, because one is for 8 countries, including Republic of Moldova, and an other was provided only inside of the country. But despite of it we established some trends in the conclusions and recommendations.
The common points are:

[15] project: "Promoting Services for People with Disabilities" (TR 0801.04) (2010-2012), program founded by WHO, EU and Government of Republic of Turkey.

[16] http://www.euro.who.int/__data/assets/pdf_file/0006/102399/E92163.pdf, pag. 74-75

[17] The report is available for internal use, it will be publish officially in a few month, we received the document from Ministry of Health of RM and our partner from Bosnia and Herzegovian. We received the permission to use some conclusions of the study officially.

- Revision of the standards of care, and identification of best practice in psychiatry in order to provide opportunity for flexible and effective approach in mental health area.
- Improvements in data collection and data publication methods in order to coordinate data collection for outpatient and inpatient care.
- Development of training packages for continuous education of health professionals working in different mental health settings.
- Developing anti-stigma campaigns and activities
- Training for carers and family support groups, and self-supportive groups of users and carers

The differences from international study and local are the general approach of mental health system, including development and implementation of new mental health documents - for example support in developing national suicide prevention strategies and strategies for employment of people with chronic mental illnesses. The international study emphasize about raising awareness among vast circles of the society on human rights in mental health through public campaigns and training of specific groups as media representatives, policy makers, municipality workers, school professionals, social workers, psychologists. And also very important recommendation was support the user association and other advocacy groups through: development, and involvement of users in national mechanism for human rights and development of mechanism for permanent involvement of users and their families in decision making processes.

Also is very relevant to be mentioned here two studies[18]: the first, 'Attitudes and Needs Assessment in Psychiatry' (Tomov 2001) examined the attitudes to mental illness and psychiatry, and the expectations for reform, that prevailed in six countries. This attitudinal study suggested that the introduction of psychiatric reforms in such circumstances might not be wise if there was little participation in the reform process by the community (as is the case in all post-totalitarian countries), particularly if this fact is not acknowledged by political and health governance institutions. The second project, 'Analytic Studies of Mental Health Policies and Services'produced descriptions (called 'mental health profiles') of countries from all World Health Organization (WHO) regions, including eastern Europe. The objective was to explore whether a generic mental health policy template (Townsend *et al.* 2004) could be developed and offered for decision-makers to use across the globe. However, one finding from the region was that after life under political dependence, the art of hypocrisy that this life had instilled within state administrations had remained – and actually became their hallmark. The conclusion was

[18] http://www.euro.who.int/__data/assets/pdf_file/0007/96451/E89814.pdf

that reforms orchestrated by those in office in the region would often be compromised by corruption (Mladenova *et al.* 2002).

The most common trends in these studies comparing to the current one are some activities like: mapping of the services around the country; support in establishment of new community mental health services and transfer the importance of mental health care from inpatient services to outpatient services.

Recently in Moldova was started very big project "The reform of mental health services in Moldova" lead by Consortium of Trimbos Institute – National Institute of Mental Health (Netherlands), Luzerner Psychiatry, Switserland, GGH Nord-Holand-Nord, Netherland and Romanian League for Mental Health and we hope this study will be usefull in drowing some conclusions and steps for.

The shifting of mental health services from institutional side to community is very important issue in mental health reform. We can see it in different study provided by international expert, including "Mental health policy in Eastern Europe: a comparative analysis of seven mental health systems" by Martin Dlouhly[19], and the main conclusion was that the burden of totalitarian history still influences many areas of social and economic life, which also has to be taken into account in mental health policy. We may observe that after twenty years of health reforms and reforms of health reforms, the transition of the mental health systems still continues. In spite of many reform efforts in the past, a balance of community and hospital mental health services has not been achieved in this part of the world yet.

First of all, it is important to mention the drivers for reforming mental health institutions relate to some points:

- Safeguarding human rights and building citizenship for all.
- Achieving better clinical and social outcomes.
- Improving patient and family satisfaction.
- Providing a more cost effective service.
- Avoiding institutionalisation and neglect.
- Reducing stigma and discrimination.

The first point is fundamental and is well-documented. It is values based. The other points are supported by a range of scientific and practice based evidence ranging across psychiatry, psychology,

[19] Dlouhy BMC Health Services Research 2014, 14:42 http://www.biomedcentral.com/1472-6963/14/42

sociology (the work of Goffman[20]) and health economics. The fifth point is illustrated mainly by ideographic evidence from inquiries and reports into institutional scandals from which no country with institutions has been immune. Also in Moldova, at the moment we have a very big scandal and litigation about sexual maltreatment of women from residential institution in one of the biggest Psychoneurological internat[21].

The economic case for deinstitutionalization – as a cost-effective move from large psychiatric hospitals to community care – is backed up by a number of studies (Stancliffe et al; Jones et al, 1984; Knobbe, Carey, Rhodes & Horner, 1995; Stancliffe & Lakin, 1998; Lapsley et al 2000). However, the issue of cost is complicated and it is necessary to take some caution when examining the evidence base. For example, Mansell & Beadle-Brown (2009) have outlined how costs can vary from country to country and this view is backed up by Knapp et al (2011): they've found that costs vary from country to country, although community care is certainly not the most expensive option. Whilst relevant to Moldova, these economic analyses will not be definitive because the inpatient services in Moldova isn't qualitative and doesn't contain all the components that would make the service expensive. For example the professional staff in one of this institution for 500 beds are only 20, but the rest of staff are the auxiliary personals. However, the general lesson on cost effectiveness of non-institutional care is important when considering how to invest.

To make a strong case for deinstitutionalization successful patient outcomes are of critical importance. Once again, there are a number of studies that demonstrate positive clinical and social outcomes. A key example in the literature on the subject is the London TAPS study, a five year follow up of 670 patients from Friern and Claybury hospitals, discharged between the years 1985 and 1998 (Thornicroft and Tansella, 2003). Not only did the study show that community-based care is more cost effective than long-stay hospital care, it also concluded that patients' quality of life was vastly improved by the move to the community. There was no overall difference seen in the pattern or severity of symptoms between deinstitutionalized patients and those who remained in hospital, and discharged patients showed no marked deterioration in their physical health (Left et al, 2000). The discharged patients themselves also had positive opinions on the change – 85% said they preferred their new accommodation to the hospital and 40% said they had noticed positive changes in themselves since leaving hospital. In addition to this, just 4% reported negative changes (Left, 1997). Also a good example is Italian studies (QUALIYOP), especially The Qualyop Project 1: Monitoring the Dismantlement of Italian Public Psychiatric Hospitals Characteristics of Patients Scheduled for

[20] Goffman, E. (2005): Asylums, Polirom, Iaşi.

[21] In Republic of Moldova the residential institutions for people with severe mental illness are named Psychoneurological Internat (Internate Psihoneurologice)

Discharge (Barbara D'Avanzo, Lucilla Frattura, Corrado Barbui, Graziella Civenti and Benedetto Saraceno,1999). Discharge was planned within twelve months for 11 % of the patients: 4% to other psychiatric or non-psychiatric institutions and 7% to community settings. For both types of discharge, an adequate network of social relationship was an important determinant. An other excellent study from Italy "Study of Long-Stay Patients Resettled in the Community After Closure of a Psychiatric Hospital in Italy" (Angelo Barbato, M.D.; Barbara D'Avanzo, Ph.D.; Gabriele Rocca, M.D.; Antonio Amatulli, M.D.; Donatella Lampugnani, M.D[22].). This study examined the outcomes of all patients who were discharged from an Italian psychiatric hospital into community residences three to four years after discharge. Of the 337 patients, 110 were transferred to nursing homes, and 163 were dis- charged to the community. The follow-up of patients who moved to the community showed no differences in psychopathology or social role functioning. In terms of overall social behavior, a significant increase was observed in the number of patients with mild or no disability, and a corresponding decrease was observed in the number with moderate dis- ability. Most patients showed residential stability. The rate of post-discharge mortality was low, and there were no deaths due to accident or suicide. The number of admissions to acute psychiatric wards was limited.

These positive outcomes are also shown in research from a number of other countries. For example, a Japanese study of deinstitutionalization of schizophrenia patients looked at 78 patients who had been moved to a community facility following the closure of Sasagawa Hospital in 2002. Out of the 78 people studied, 60 residents showed significant improvements in both psychiatric symptoms and social functioning (Ryu, 2006). An Australian study looked at forty-seven patients with long-term mental illness who were moved to a community setting following the closure of a psychiatric hospital in Sydney in 2000. After a 6 year evaluation - an extension of an initial detailed clinical, ethnographic and economic study after the first 2 years – the researchers concluded that 'clinically, community residents remained stable over the 6 years without significant changes in psychiatric symptoms, depression, living skills or social behaviour problems'. There was also a 'significant reduction in medication levels' and the patients themselves expressed a preference for living in the new community setting (Hobbs et al, 2000). Similar results have been found in other studies (e.g. Okin et al, 1983).

Some studies have also looked at mortality rates. One Finnish study that looked at the impact of deinstitutionalization of mental health care between 1981-2003 reached the conclusion that 'Deinstitutionalization and decentralization of mental health services did not affect life expectancy negatively' (Westman et al, 2012). In addition to this, another Finnish study has demonstrated a

[22] http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.55.1.67, Psychiatric services, January 2004 Vol. *55* No. 1, pag. 67-70

reduction in suicide mortality of men with schizophrenia after deinstitutionalization (Rantanen et al, 2009). The London TAPS study showed that moving patients to the community did not increase the patient death rate or suicide rate (Leff, 1997).

In international practice we have a good example of study that emphasize the third item of reforming mental health "improving patient and family satisfaction" – EPSILON STUDY, namely "Satisfaction with mental health services among people with schizophrenia in five European sites" by Mirella Ruggeri, Antonio Lasalvia, Qiulia Bisoffi, Qraham Thomicroft, Jose Luis Vazquez'Barquerot Thomas Becker, Martin Knapp, Helle Charlotte Knudsen, Aart Schene, Michele Tansella, and the EPSILON Study Qroup (Schizophrenia Bulletin, Vol.29, No2, 2003). Patient satisfaction with services is an important outcome variable that is increasingly used in mental health service evaluation. This study includes 404 people with schizophrenia in five European sites and addresses five questions focused on site, service, and patient characteristics as variables that might explain service satisfaction, using the Verona Service Satisfaction Scale.

In comparison with the study provided in my country we didn't have the aim to identify the level of satisfaction. The common point was the autonomy and possibility to leave in community, namely the community needs.

On the second time, taking into consideration that the similar study was provided in Turkey, we will try to compare the results between Moldova and Turkey. The major difference between these two studies was that in Turkey they evaluate all beneficiaries from all institutions, including community-based, but in our study we addressed two categories: - beneficiaries from PH and residential institutions. On the level of *individual assessment:* Most residents were admitted in institutions, since official data, for continuing care. Actually we can conclude that their families had difficulties and these people were abandoned. In psychiatric hospitals the situation did not differ very much: approximately half of all PH patients that were interviewed were admitted to the hospital because of their psychiatric condition worsening. Despite the goals of all institutions were different, both promoted more social than medical care. In Turkey the stated reasons for hospitalisation as perceived by the patients themselves were: s/he is ill (but do not know what it is) with 25% and s/he is in the institution with the request of family/legal guardian – 14%.

We noticed that in psychiatric hospitals we could meet people who were permanently hospitalized, so the hospital was not only for crisis intervention, but also for chronic non-official social care. All data from both institutions showed that mental health care services were scarcely specialized, with no multidisciplinary approach or psychosocial rehabilitation. Another important issue was the level of disability of users, given three quarters of the patients admitted to both institutions were in a state of disability.

Some clear findings emerged about the lives of patients/residents in both countries:

- Only about half of patients had any contact with their families.
- Patients had a number of issues requiring psychological support or attention in rehabilitation. Problems in use of verbal language were the most common (nearly a half) and confusion and mobility problems were also common;
- However, day to day support needs in the population were not particularly high, only a minority had extensive requirements for support with day to day tasks.

Study demonstrates that the majority of beneficiaries from both institutions could live in the community with a regular or occasional support, but must take into account that in fact there are still many social factors that might influence the autonomy of people: family and relatives, the existence of social networks in institutions, lack of social relationships in the community, acts of origin, and not at least, the desire of beneficiaries to leave the institution.

The assessment allowed to rate the overall level of support required by the interviewee in order to give a broad sense of their dependency levels. Looking into one's degree of self-sufficiency (autonomy) in Moldova and Turkey *we* may conclude that there were very few fully dependent residents in general, especially in Turkey (tab. 5.1.).

Table 5.1. Self-sufficiency of residents in mental health institutions in Moldova and Turkey.

	in Moldova	In Turkey
Self-sufficient	19,4 %	19,4 %
Occasional support	70 %	37 %
Regular support	20 %	29 %
Fully dependent	0.6%	15,6 %

Thirdly, in institutional assessment we found similar properties in both countries. It is a clear finding of the needs assessment and analysis that the institutional care system in Turkey and Moldova follows the classic pattern of institutional care observed in the international literature over the last 50 years:

- The infrastructure is of variable quality, and even if high quality it is physically isolated and too institutional;
- There is an inadequate skill mix and knowledge in the workforce, inadequate numbers of professional staff doing wrong things, and widespread institutionalisation of staff as well as of patients;
- Patients are not treated as individuals, but objects of care;

- Many patients just spend their days eating, sleeping and hanging around with little or no meaningful activity;
- There is a complete lack of individualised therapeutic goals for patients and a lack of hope or indeed any alternative options for the future, an exception being the higher quality of children's facilities;
- There is a lack of opportunity for all sorts of experiences that are open to other citizens, many of which could be arranged quite easily even in the current system;
- There is a lack of connectedness with the rest of society, the institutions are like islands;
- In some cases there are poor institutional practices and sometimes human rights abuses;
- There are bureaucratic barriers and negative incentives in administrative procedures and policies which seem to hinder progress but because the study was focused only at local level this issue would require separate analysis to suggest solutions;
- There is a lack of leadership, good management practice in accordance with international evidence, staff supervision, learning and quality systems.
- Either psychiatric hospitals or residential institutions were not acceptable and appropriate for providing mental health services according to international requirements. In context of Moldova, which is a very poor country, many people living in families don't have a decent life conditions, including primary needs, and sometimes the institutional care "solve" these social problems.

We have identified six long-term trends in visions of good care for people with serious mental health issues. Symptom stabilization is no longer the sole or primary aim: personal and social recovery are equally important. Second, professional input should be accompanied by activities that flow from the personal strength, commitment and energy of the individual concerned. Third, good treatment, guidance and support should target not only the patient but also his/her immediate circle. Fourth, inter-sectoral cooperation must be in place. Fifth, more and more interventions are combining treatment with rehabilitation. Finally, psychiatric and somatic care need to be better integrated to restore the physical health of these patients. These six trends have concrete implications in the search for the best way to organize treatment, guidance and support.

Finally I would like to mention that this study has raised much debate among policymakers and it is obvious that the process of institutionalization is difficult and economically disadvantageous at the moment, but it is necessary. Social and financial burden of mental health in RM should be quantified in order to estimate the duration and funds for mental health reform.

CHAPTER VI - CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary conclusions

1. In the context of Article 19 of the CRPD, setting forth the rights of all persons to live in the community, MH facilities in the Republic of Moldova do not comply with the UN Convention on the Rights of Persons with Disabilities and do not meet the best practices of care rendered to people with disabilities.

2. Most PNBH residents were admitted for social reasons as compared to just few cases in PH, yet there were some.

3. As many as 37% of PNBH residents are deprived of legal capacity, having been assigned a guardian, meaning that one has to secure the approval from their guardian to get them (re)integrated into the community.

4. The number of PH residents visited by family is three times that of PNBH residents, meaning that PNBH residents are actually, by and large, abandoned.

5. The number of persons with intellectual disability within PNBH is inversely proportional to the number of persons with mental health problems within PH. This cross-comparison is explicitly indicative of the type of services being provided: PH rendered more mental health problem related services, whereas PNBH provided social care services.

6. Only half of the PNBH respondents required support therapy, as compared to most PH respondents; thus a good share of people to be deinstitutionalized would require no specialized medical support.

7. There were few fully dependent persons reported, all – within PNBH.

8. There were fully self-sustained residents in both types of facilities; yet, their number was three times larger in PH.

9. Most respondents from either facility (PNBH or PH) required occasional support, i.e. 1–2 times a month.

10. Of all PNBH residents, about one-third required periodical support (1–2 times a week) versus less than 3% in PH respondents.

11. The condition of respondents was worse in PNBH than in PH. However, yet, those ready to be deinstitutionalized accounted for most of respondents there.

12. All hospitals had the resident's consent to admission and treatment, whereas there was no consent in PNBH whatsoever.

13. It is quite obvious that both the hospitals and residential care system do not achieve their intended purpose, meaning that the majority of residents may be deinstitutionalized without any support therapy.

14. Obviously, the situation in the PH in Orhei is unacceptable. Given that, there is a clear need for the MoH to step in with urgent measures, regardless of the Deinstitutionalization Plan.

6.2 Limitations of the study

The study was limited by the following:

1. The sample of 10% is not representative for national level, but it shows a trend in mental health institutions.

6.3 Recommendations

1. MH service reforms shall occur in stages or shall be guided by a clear hierarchy of needs, with specific and concrete actions:

   - *Need to understand the issue* – situation analysis countrywide, assessment of each facility and beneficiary;

   - *Need to plan the process* – setting up cross-sector collaboration by establishing a working group at central level to develop an ambitious, yet comprehensive and complex deinstitutionalization plan to shut down facilities.

   - *Need for concrete actions* – a critical factor at this stage of reform implementation is the political commitment of all stakeholders.

   - *Need to coordinate the process* (leadership) – setting up a (deinstitutionalization) reform steering committee at central level and a mobile response team for each case of deinstitutionalization;

2. Stop investing in and carrying out major renovation projects in large MH facilities, mainly PNBH. Invest in scaling up the number of slots within existing community services and build up new programs / services for the persons with mental disabilities.

3. Stop referring people with mental disabilities to PNBH or PH on social grounds as well as putting them on a waiting list. Stop admitting new residents to those 4 PNBH to avoid any further increase in the number of institutional residents.

4. Develop a deinstitutionalization plan and prevent any further admission of all persons with mental disabilities, based on values such as fairness, self-sufficiency and social inclusion of the disabled.

5. Make sure that the aforesaid plan will not just "reshape" those facilities, but rather will gradually shut them down, including the development of a wide array of alternative services for the people with mental disabilities. Make sure that averting the admission of the disabled is an integral part of the above plan. The plan shall include specific milestones and an implementation timeframe, as well as indicators and funding.

6. In order to enforce the deinstitutionalization plan, one has to perform the medical and psychosocial assessment of residents from each type of facilities (PNBH and PH), while developing an individual plan for community (re)integration (if appropriate).

7. Develop a plan of care for each person with mental disability within the health and social care systems, while briefing them about the specifics of services and the care they may benefit from to live and get integrated into the community. In planning your actions, take the advice of the families if those get involved in the life of a facility.

8. Prepare PNBH residents to become self-sufficient by organizing trainings in life skills and by building their capacity to live in the community. Provide support and help to transfer all residential care beneficiaries to the community.

9. Make facilities get involved in deinstitutionalization by encouraging staff to develop alternative programs, preparing the residents for community life and gradual reallocation of staff to community care.

10. Retraining of staff working in existing facilities in how to render community care to people with mental disabilities.

11. Reorganize psychiatric hospitals by downsizing and changing the profile of existing beds.

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ANNEXES

Annex 1

TOOL FOR INDIVIDUAL ASSESSMENT OF RESIDENTS OF MENTAL HEALTH FACILITIES

Dear Sir or Madam,

In order to evaluate the individual needs and self-sufficiency of beneficiaries of mental health residential care services in the Republic of Moldova, we would like to invite you to participate in the survey: "**Assessing the community needs of mental health residential care service users in the Republic of Moldova**".

The survey collects answers to 40 questions and takes approximately 20 minutes to do.

Participation in the survey is absolutely voluntary. If you decide not to participate in the survey, you shall bare no punitive consequence. The survey is anonymous (the questionnaire with questions does not provide for entering your name), and the findings shall be used for professional and research purposes only to be published in scientific literature.

If you agree to take part in the survey, please sign an informed consent.

Thank you for cooperation! _____

CHAPTER 1 – PERSONAL DETAILS:

1. Address / facility	
2. DOB	
3. Sex	
4. Age	
5. Date of admission **(If hospitalized more than once, specify and enter the date of last admission. If readmitted to a different facility, pls. specify which one)**	_____ How many times admitted?_____ În care instituţii (în caz dacă diferă)_____

6. Reason for admission	- From the medical chart _____ - On patient's accounts
7. What is the duration of your current stay?* **7A. What is the total duration of all your admissions to different facilities?**	- From the medical chart _____ - On patient's accounts _____
8. Hospitalized from where?	1. One's own home 2. Family's home 3. Transferred from another facility _____ 4. Other _____
9. Education*	1. Primary 2. Incomplete secondary 3. General secondary 4. Specialized secondary 5. Incomplete higher 6. Higher
10. What is your occupation?*	
11. Record of work	
12. Do you have a disability degree?*	1. Yes 2. No
13. You have the following disability degree:*	1. I degree II degree III degree 2. Indefinite period of time Time-limited
14. What is the duration of your sickness?*	

15. Is a resident's habitual way of living observed in the facility? (check all that apply)	**1.** Personal care **2.** Diet **3.** Clothing **4.** Haircut **5.** Faith **6.** Holidays **7.** Other _____
16. Language(s) spoken	
17. Do you have a guardian?	- Yes - No
18. Do you have a family?	- Yes - No Do you visit each other? - Yes - No Do you have regular contact with your family? - Yes - No

Chapter 2 – Health:	
Diagnosis **Check all that apply**	Intellectual disability: 1. Autism 2. Epilepsy 3. Down syndrome 4. Cerebral palsy

	5. Acquired cerebral trauma 6. Mental retardation 7. Other _____ Mental health: 1. Schizophrenia / other psychoses 2. Bipolar disorders 3. Depression 4. Anxiety 5. Personality disorders 6. Substance abuse / dependence 7. Nutrition disorders 8. Other _____
Difficulties **Check all that apply**	1. Difficult behaviors 2. Use of verbal language 3. Anxiety 4. Aggressive conduct 5. Locomotion 6. Confusion 7. Abstinence 8. Disorientation to time, space, person 9. Hallucinations and other deliria 10. Other _____
Other health conditions **Check all that apply**	1. Diabetes mellitus 2. Heart conditions 3. High / low blood pressure 4. Thyroid conditions 5. Hepatitis 6. HIV 7. Eyesight 8. Hearing 9. Other _____

Do you need support therapy?	Yes _____ No _____
Do you have locomotor (mobility) needs, e.g. wheelchair, walkers, walking aids?	Yes _____ No _____
Special diet needs	Yes _____ No _____
Allergy	Yes _____ No _____

2.1. Physical Health

This chapter refers to the support that a person might need in order to manage one's own physical health, i.e. when someone falls sick and how could one avoid such situations.

Check one Box that apply best ☑

1. One may provide for and manage own health needs (self-sufficient)	☐
2. One requires occasional support to manage own health needs (1-2 times a month)	☐
3. One requires regular support provided by others in order to make sure they feel okay (3-5 times a week)	☐
4. One requires daily support for their health issues	☐

Concerns about health needs and ways to manage those **Check all that apply**	1. Provides for one's own health needs 2. Health worsened suddenly and unpredictably 3. Has several health needs 4. Others are concerned about health needs 5. Other_____

2.2 Mental Health – Psychiatric Symptoms

This chapter refers to the support that one may need to manage the change in their mental health, e.g. when they fall sick or are disturbed, or how could they avoid getting to such situations.

Check one Box that apply best ☑

1. One may provide for and manage own mental health needs (self-sufficient)	☐
2. One requires occasional support to manage own mental health needs (1-2 times a month)	☐
3. One requires regular support provided by others in order to ensure their mental wellbeing (2-3 times)	☐
4. One requires daily support for their mental health issues	☐

Concerns about mental health needs and ways to manage those **Check all that apply**	1. There are no concerns ascertained regarding one's mental health needs 2. Mental health has its ups and downs 3. Mental health may worsen suddenly 4. One has several mental health needs and people are admitted or are given medication to keep conditions under control 5. Other_____

2.3 Mental Health – Psychological Needs

This chapter refers to one's psychological needs and the way one is coping with own sufferings in the past, present or future.

1. One may provide for and manage own psychological needs (self-sufficient)	☐
2. One requires occasional support to manage own psychological needs (1-2 times a month)	☐

3. One requires regular support provided by others in order to make sure they cope with their psychological needs (2-3 times)	☐
4. One requires daily support to cope with own psychological needs	☐

3. Communication

This chapter looks at the way a person is communicating and how others understand a person.

Check one Box that apply best ☑

3.1 Communication with Others – Expressive

1. One may communicate and express own needs by means of words	☐
2. One may communicate by using a language and additional means **(if checked, go to Section A and fill it in)**	☐
3. One may not communicate verbally, but make use of other communication means. **(if checked, go to Section A and fill it in)**	☐
4. Many not communicate by other means and depend on others to perform communication.	☐

Section A **How can a person communicate with you?** **Check all that apply.**	1. Sign language 2. Symbols 3. Communication devices 4. Gestures 5. Images 6. Imitation 7. Other_____

Check one Box that apply best ☑

3.2 Means whereby a person understands what's happening around – Receptive language	
1. One understands people when talked to	☐

2. One understands others with some support **(if checked, go to Section A and fill it in)**	☐
3. One's understanding is limited, but understands simple instructions; e.g., eat, get out, go to bed, etc.	☐
4. One may not show if he/she understands others.	☐

Section A **How does one understand others?** **Check all that apply**	1. Sign language 2. Symbols 3. Communication devices 4. Gestures 5. Images 6. Imitation 7. Other_____

Chapter 4 – Daily Support Needs

4.1 Healthy Nutrition

This chapter looks into the support one may need to eat.

Check one Box that apply best ☑

1. One requires no support to eat	☐
2. One requires frequent support or encouragement to eat (e.g., at least daily)	☐
3. One always requires support to eat (several times a day)	☐

If you checked 2 or 3, then answer the following question: **Any adaptations or tools needed to eat?** **Check all that apply**	1. Fed through one's nose / stomach 2. Sitting on a chair 3. Tray 4. Special glass / cup 5. Plate 6. Eating utensils (tableware) 7. Other_____

4.2 Healthy Intake of Fluids

This chapter looks into the support one may need to drink.

Check one Box that apply best ☑

1. One does not require support to drink fluids	☐
2. One requires frequent support or encouragement to drink fluids (e.g., at least once a day)	☐
3. One always requires support to drink fluids (several times a day)	☐

If you checked 2 or 3, then answer the following question: Any adaptations or tools needed to drink? Check all that apply	1. Fed through one's nose / stomach 2. Sitting on a chair 3. Tray 4. Special glass / cup 5. Plate 6. Eating utensils (tableware) 7. Other _____

4.3 Safety

This chapter considers the support needed for one to be safe. Please, indicate for each line how often the support is needed.

Then, state if the support is required during daytime, evening or both **(occasional = 1-2 times a month; regular = 3-5 times a week)**

	Line	1. Never needs support	2. Needs occasional support	3. Needs regular support	4. Always needs support	Daytime	Nighttime	Both
1	Getting furious							
2	Falls (fits of seizures)							

3	Wandering (getting lost)							
4	Being aware of pathway							
5	Avoidance or tackling of abuse							
6	Avoidance or tackling of exploitation							
7	Intake of drugs							

4.5 Personal Care

This chapter considers the support needed for one to take care of himself/herself. Please, indicate for each line how often the support is needed. Then, state if the support is required during daytime, evening or both **(occasional = 1-2 times a month; regular = 3-5 times a week)**

	Line	**1. Never needs support**	**2. Needs occasional support**	**3. Needs regular support**	**4. Always needs support**	**Daytime**	**Nighttime**	**Both**
1	Getting up							
2	Going to bed							
3	Washing							
4	Getting dressed							
5	Using WC							
6	Tooth brushing							
7	Care during menstruation							
8	Shaving							
9	Nail trimming							
10	Bathing / getting a shower							
11	Use of eye glasses							
12	Wearing a hearing device							
13	Washing one's cloths							
14	Other							

4.7 Daily Tasks

This chapter considers the support needed for one to perform his/her daily tasks. Please, indicate for each line how often the support is needed. Then, state if the support is required during daytime, evening or both **(occasional = 1-2 times a month; regular = 3-5 times a week)**

	Line	1. Never needs support	2. Needs occasional support	3. Needs regular support	4. Always needs support	Daytime	Nighttime	Both
1	Management of money							
2	Getting gifts, postcards, letters							
3	Use of telephone / mobile							
4	Listening to music							
5	Watching TV							
6	Cleaning up one's personal space, e.g. bedroom							
7	Use of public transportation							
8	Other							

4.8 Leisure and Personal Connections

This chapter examines one's **participation** in such activities, which are important to the person and that are of interest to him/her. Please, check those activities that the person is getting involved in. This table shall not count towards the final score!!!

	Line	Please, check if important to the respondent
1	Faith-related activities	
2	Cultural activities	
3	Partner	
4	Hobbies (arts, handicrafts, reading, writing, music, TV, cooking, etc.)	
5	Job (work)	
6	Ergotherapy	
7	Training courses	
8	Visiting family	

9	Visiting friends	
10	Sports	
11	Exercise (swimming, walking)	
12	Other	

This chapter looks into the **support** requested by one to enable him/her participating in the activities that are important to him/her and are of interest (*activities checked in the table above*).

Please, indicate how often the support is needed **(occasional = 1-2 times a month; regular = 3-5 times a week)**

	Line	1. Never	2. Occasionally	3. Regularly	4. Always
1	Faith-related activities				
2	Cultural activities				
3	Partner				
4	Hobbies (arts, handicrafts, reading, writing, music, TV, cooking, etc.)				
5	Job (work)				
6	Ergotherapy				
7	Training courses				
8	Visiting family				
9	Visiting friends				
10	Sports				
11	Exercise (swimming, walking)				
12	Other				

Do you go out to community?	- Yes - No **If Yes, how often a month?** 1-2 3-4 5-6 7-8 more than 8

4.9 Unpaid Work, Jobs, Professional Activities

This chapter examines the opportunities for residents to engage in ergotherapy, professional, education and/or work-related activities, enjoying their spare time and using their money **(Occasionally = 1-2 times a month; regularly = 3-5 times a week)**

Check one Box that apply best ☑

1. One may independently participate, on a regular basis, in volunteer, professional, education and/or work-related activities **(list applicable activities)**	☐
2. One requires occasional support to participate, on a regular basis, in volunteering, professional, education and/or work-related activities **(list applicable activities)**	☐
3. One requires regular support to participate volunteering, professional, education and/or work-related activities **(list applicable activities)**	☐
4. One always requires support to participate in volunteering, professional, education and/or work-related activities **(list applicable activities)**	☐
5. One never participates in volunteer, professional, education and/or work-related activities, as one may no longer do so.	☐

Chapter 5 – Filling in the Questionnaire	
Hereby, I confirm that the data from this questionnaire is accurate as of the date it was shared	
Name of person filling in the questionnaire	
Signature	**Date**